

Chapter 2

Overview of crystal methamphetamine and its use in Australia

2.1 This chapter provides a summary of crystal methamphetamine and its use in Australia. It first defines crystal methamphetamine and how it differs from other methamphetamine substances; it then explores the following matters:

- Crystal methamphetamine use in Australia, the number of users and the difficulty estimating the quantity of crystal methamphetamine consumed each year.
- Problematic versus non-problematic use and the identification of groups at risk of developing problematic consumption behaviours.
- The mental and physical effects of crystal methamphetamine, specifically methamphetamine-induced psychosis and violent behaviours demonstrated by some users.
- Drivers of crystal methamphetamine use and factors that contribute to problematic use.
- Price, purity and methods of administration.
- Poly-drug use as a feature of crystal methamphetamine use and how this influences users' health outcomes.
- National data on illicit drug arrests and illicit drug offences recorded in the criminal courts of each state and territory.

What is crystal methamphetamine?

2.2 Crystal methamphetamine is a form of methamphetamine,¹ grouped under the class of amphetamine-type stimulants (ATS). The term 'crystal' refers to its crystalline structure, which gives the substance the appearance of crushed ice,² hence its colloquial name of 'ice'.

2.3 Various common or street names for methamphetamines with reference to their forms and methods of administration are outlined in Table 1.

1 According to the *Illicit Drug Data Report 2014–15*, there are four common forms of methamphetamine. They are: tablet, crystal (ice), base (referred to as 'paste') and powder (referred to as 'speed'). See, Australian Criminal Intelligence Commission (ACIC), *Illicit Drug Data Report 2014–15*, 4 August 2016, p. 24.

2 ACIC, *Illicit Drug Data Report 2014–15*, 4 August 2016, p. 23.

Table 1: common names for methamphetamines³

Drug type	Common names	Forms	Method of administration
Methamphetamine	<p>Meth, speed, whiz, fast, uppers, goey, louee, Lou Reed, rabbit, tail, pep pills.</p> <p>In paste form it can be referred to as base, pure or wax.</p> <p>In liquid form it can be referred to as ox blood, leopard's blood, red speed or liquid red.</p>	White, yellow or brown powder, paste, tablets or a red liquid	Oral, intranasal, injection, anal.
Crystal methamphetamine	Ice, dmeth, glass, crystal, batu, shabu (in South-East Asia)	Crystalline	Smoking, intranasal, injection

2.4 Some evidence presented in this report refers to crystal methamphetamine specifically, while other evidence describes methamphetamine and/or amphetamine. Generally, methamphetamine is referred to when specific data on crystal methamphetamine is not available. Australia's federal law enforcement agencies refer to methamphetamine as methylamphetamine.

2.5 During the course of the inquiry, many witnesses rejected the term 'ice' on the basis this term can have positive connotations and potentially encourage use. For this reason, this report refers to crystal methamphetamine, methamphetamine or amphetamine, as appropriate, unless directly quoting evidence where another name for the drug was used.

Crystal methamphetamine use in Australia

2.6 Accurately ascertaining crystal methamphetamine use in Australia is difficult, as it is for all illicit substances, due to a paucity of data and limitations on the accuracy of the data that is available. Despite this, Australia has a number of initiatives and longitudinal studies that provide authorities and those working in the alcohol and other drug (AOD) sector with some insight into the consumption of illicit substances. These include:

- the National Drug Strategy Household Survey (household survey);

3 ACIC, *Illicit Drug Data Report 2014–15*, 4 August 2016, p. 23.

- the Drug Use Monitoring in Australia (DUMA) program;
- the Illicit Drug Reporting System (IDRS);
- Clients of Alcohol and Other Drug Treatment Service (AODTS); and
- the recently established National Wastewater Drug Monitoring Program.

2.7 These initiatives are discussed in detail below.

National Drug Strategy Household Survey

2.8 Every three years the Australian Institute of Health and Welfare (AIHW) conducts the household survey and reports on alcohol, tobacco and illicit drug use in Australia. The survey includes data on people's attitudes and perceptions about alcohol, tobacco and illicit drug use. The survey allows the AIHW to collect data from nearly 24 000 people⁴ across Australia, mostly aged 14 years or older.⁵

Key findings from the 2016 National Drug Strategy Household Survey⁶

2.9 The 2016 household survey showed a decline in recent self-declared use (defined as use of an illicit drug in the last twelve months) of meth/amphetamine from 2.1 per cent in 2013 to 1.4 per cent in 2016. Data from the household survey indicates that the percentage of people using meth/amphetamine has continued to decline since 2001 (see Table 2).

Table 2: Meth/amphetamine drug use, people aged 14 years or older, 1993 to 2016⁷

Year	1993	1995	1998	2001	2004	2007	2010	2013	2016 ⁸
Meth/amphetamine⁹ (per cent)	2.0	2.1	3.7	3.4	3.2	2.3	2.1	2.1	1.4

2.10 Despite the overall decline, the 2016 survey demonstrated that crystal methamphetamine remains the preferred form of meth/amphetamine for users: 57 per cent of recent users reported that crystal methamphetamine is their main form

4 The National Drug Strategy Household Survey (NDSHS) is a triennial population survey that provides data on the use of alcohol and other drugs in Australia. Due to the survey being a household survey, it omits institutionalised people and people not living in private dwellings.

5 Australian Institute of Health and Welfare (AIHW), *National Drug Strategy Household Survey (NDSHS) 2016 Key findings (NDSHS 2016 Key findings)*, <http://www.aihw.gov.au/alcohol-and-other-drugs/data-sources/ndshs-2016/key-findings/> (accessed 3 July 2017).

6 The 2016 survey was conducted from 18 June 2016 to 29 November 2016.

7 AIHW, *Submission 6*, p. 7.

8 AIHW, *NDSHS 2016 Key findings*, <http://www.aihw.gov.au/alcohol-and-other-drugs/data-sources/ndshs-2016/key-findings/> (accessed 3 July 2017).

9 For non-medical purposes.

of meth/amphetamine used in the previous 12 months (an increase of 7 per cent compared to 2013).¹⁰ This result continues an upward trend observed since 2010 (see Table 3).

Table 3: Main form of meth/amphetamine used in last 12 months, people aged 14 years or older, 2007 to 2016¹¹

Drug	2007	2010	2013	2016
Powder/Speed	51.2	50.6	28.5	20.2
Crystal/ice	26.7	21.7	50.4	57.3
Base/paste/pure	12.4	11.8	7.6	1.6
Tablet	5.1	8.2	8.0	5.6
Prescription amphetamines	3.2	6.8	3.0	11.1
Liquid	1.3	0.9	0.5	n.p
Capsules	NA	NA	2.0	3.8

2.11 The 2016 survey also reported that the frequency of meth/amphetamine use has increased, in particular for those people using crystal methamphetamine (see Tables 4 and 5).

10 AIHW, *NDSHS 2016 Illicit use of drugs*, <http://www.aihw.gov.au/alcohol-and-other-drugs/data-sources/ndshs-2016/illicit-drug-use/> (accessed 3 July 2017).

11 AIHW, *NDSHS 2016 Key findings table*, <http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129559847> (accessed 3 July 2017).

Table 4: Frequency of meth/amphetamine use by recent users aged 14 years or older (all recent meth/amphetamine users)¹²

Frequency of use	2007	2010	2013	2016
At least once a week or more	13.0	9.3	15.5	20.4
About once a month	23.3	15.6	16.6	10.6
Every few months	27.9	26.3	19.8	24.7
Once or twice a year	35.6	48.8	48.0	44.3

Table 5: Frequency of meth/amphetamine use by recent users aged 14 years or older (frequency of crystal methamphetamine use)¹³

Frequency of use	2007	2010	2013	2016
At least once a week or more	23.1	12.4	25.3	31.9
About once a month	24.3	17.5	20.2	8.3
Every few months	20.7	23.1	14.3	22.6
Once or twice a year	31.8	47.0	40.2	37.3

Perceptions and attitudes towards meth/amphetamine

2.12 The household survey also surveys respondents' perceptions and attitudes towards illicit drugs. Despite the overall decline in use, the perception that meth/amphetamines are causing social and criminal problems has increased.

2.13 Household survey data shows a significant increase in the number of people who believe that meth/amphetamines are the most concerning drugs for the general community and in 2016, for the first time, meth/amphetamines overtook the excessive consumption of alcohol as the drugs of most concern (see Table 6).

12 AIHW, *NDSHS 2016 Key findings table*, <http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129559847> (accessed 3 July 2017).

13 AIHW, *NDSHS 2016 Key findings table*, <http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129559847> (accessed 3 July 2017).

Meth/amphetamines were also considered the drugs most likely to be associated with a 'drug problem' (21.9 per cent in 2013 to 46.4 per cent in 2016).¹⁴

Table 6: Drug thought to be of most concern for the general community, people aged 14 years or older, 2007 to 2016¹⁵

Drug	2007	2010	2013	2016
Excessive drinking of alcohol	32.3	42.1	42.5	28.4
Cannabis	5.7	4.5	3.8	2.6
Meth/amphetamine	16.4	9.4	16.1	39.8
Cocaine	8.3	6.1	3.6	3.3
Ecstasy	6.0	5.5	5.2	5.0
Heroin	10.5	11.4	10.7	7.5

2.14 The 2016 household survey noted that factors, such as media coverage and personal experiences, are likely to influence the opinions of respondents in terms of perceptions of and attitudes towards illicit drugs.¹⁶

2.15 The committee heard evidence from Professor Rebecca McKetin in 2015 and again in 2017. Professor McKetin referenced a detailed study of the household survey conducted by Professor Anne Roche. This study showed that prevalence of use was stable but this was not consistent across regions. It found use in regional areas had increased, whilst it had decreased in metropolitan areas. Professor McKetin said researchers have followed these indicators and:

...there is certainly a broad range of indicators consistently showing an increase. There is definitely an increase in the level of problematic use and there is a little evidence of an increase in the uptake of use too, but I think it is important to understand that the situation is not the same everywhere, so you cannot make one sweeping statement that things have not changed.¹⁷

14 AIHW, *NDSHS 2016 Key findings table*, <http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129559847> (accessed 3 July 2017).

15 AIHW, *NDSHS 2016 Key findings table*, <http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129559847> (accessed 3 July 2017).

16 AIHW, *NDSHS 2016 Illicit use of drugs*, <http://www.aihw.gov.au/alcohol-and-other-drugs/data-sources/ndshs-2016/illicit-drug-use/> (accessed 3 July 2017).

17 Professor Rebecca McKetin, Curtin Senior Research Fellow, National Drug Research Institute (NDRI), Curtin University, *Committee Hansard*, 3 May 2017, p. 34.

2.16 Professor McKetin also explained that the study of the household survey shows evidence that there has been under-reporting of methamphetamine use, which she believes may explain for the disparate trends in other indicators and the survey.¹⁸ Professor Steve Allsop from the National Drug Research Institute (NDRI) added that:

We also have to recognise that, for all sorts of reasons, we end up with underreporting. There is a high nonresponse rate. Many of the people who might be particularly at risk are more likely to be non-respondents; for example, people who are in the prison system, people who do not have phones or addresses that are easily contactable, people who choose not to respond—or to not respond accurately—or sometimes people do not even know accurately. For example, if you ask people how much alcohol they have consumed, some people underreport deliberately and some people do not have a good idea.¹⁹

2.17 This issue had been raised by Professor McKetin in earlier evidence provided to the committee:

There is also an issue with population surveys that they quite strongly underrepresent problematic drug use, and they are very sensitive to any stigma around drug use. There is negative publicity, and we have seen this before for methamphetamine; you get strong underreporting. If you look back to the 2001 survey, almost 10 per cent of Australians said they had ever used speed, amphetamine and methamphetamine. By 2007, after all of the bad press, that fell to 6 per cent. Suddenly 4 per cent of Australians who had used methamphetamine no longer have used methamphetamine. That is the extent of underreporting that you can get.²⁰

2.18 The Department of Health addressed the issue of under-reporting in the household survey. It acknowledged that having people admit to an illegal activity may lead to under-reporting, but:

That is the way people answer, and there is nothing you can do to control that. However, I would point to, if there is underreporting—and I do not know whether there is—you can still look at the trends in the data. You would assume that you would be getting the same kind of underreporting or over-reporting or whatever it might be. The way statisticians work with data is to work out what the degrees of error are.²¹

18 Professor McKetin, Curtin University, *Committee Hansard*, 3 May 2017, p. 34.

19 Professor Steve Allsop, Project Leader, NDRI, Curtin University, *Committee Hansard*, 3 May 2017, p. 34.

20 Professor McKetin, Curtin University, *Committee Hansard*, 9 September 2015, p. 11.

21 Dr Wendy Southern, Deputy Secretary, Department of Health, *Committee Hansard*, 9 September 2015, p. 18.

Drug Use Monitoring in Australia program

2.19 The DUMA program measures drug use amongst police detainees from nine sites across Australia. This ongoing study examines the relationship between drugs and crime, local drug markets and patterns of use by detainees. DUMA data is collected and published periodically by the Australian Institute of Criminology (AIC). Its last publication was on 9 February 2016, as a part of a series of papers about methamphetamine use and the perspectives of DUMA police detainees.²² The *Drug use monitoring in Australia: 2013–14 report on drug use among police detainees* is the last full year analysis publicly available on the AIC website, but the Australian Criminal Intelligence Commission's (ACIC) *Illicit Drug Data Report 2015–16* notes results from the 2014–15 and 2015–16 DUMA examinations.

2.20 According to the *Illicit Drug Data Report 2015–16*, the number of detainees testing positive for amphetamine use increased, from 40.9 per cent in 2014–15 to 50.5 per cent in 2015–16. This recent result marked the 'highest percentage reported in the last decade'.²³ The ACIC identified the increase in detections of methamphetamine (methylamphetamine) use in detainees as the reason for the continued upward trend in detections, with data showing an increase from 38.7 per cent in 2014–15 to 49 per cent in 2015–16. Further:

The proportion of detainees testing positive for methylamphetamine continues to be higher than the proportion testing positive for MDMA,²⁴ heroin, cocaine, benzodiazepines and opiates (excluding heroin). In 2015–16, the proportion of detainees testing positive for methylamphetamine was higher than the proportion testing positive for cannabis (44.4 per cent). In 2015–16, 59.7 per cent of detainees self-reported recent methylamphetamine use, an increase from the 50.4 per cent reported in 2014–15.²⁵

Illicit Drug Reporting System

2.21 Since 1999, the IDRS has monitored illicit drug use across all states and territories. The IDRS provides a coordinated monitoring system with a particular focus on heroin, methamphetamine, cocaine and cannabis. The IDRS comprises interviews with people who inject drugs, interviews with experts, and the examination

22 Australian Institute of Criminology (AIC), *Drug use monitoring in Australia (DUMA)*, http://www.aic.gov.au/about_aic/research_programs/nmp/duma.html (accessed 30 March 2017).

23 ACIC, *Illicit Drug Data Report 2015–16*, 30 June 2017, p. 43.

24 3,4-Methylenedioxymethamphetamine.

25 ACIC, *Illicit Drug Data Report 2015–16*, 30 June 2017, p. 43.

of other data sources, such as opioid overdose data, treatment data, and purity of seizures of illicit drugs made by law enforcement agencies.²⁶

2.22 Key findings from the IDRS for 2016 showed:

- 75 per cent of the national sample reported 'using one or more forms of methamphetamine in the last six months on a median of 36.5 days', significantly higher than the 2015 median of 24 days;²⁷
- recent use of crystal methamphetamine was significantly higher, with use increasing from 67 per cent in 2015 to 73 per cent in 2016;
- the frequency of use in the last six months for crystal methamphetamine had increased from 20 days in 2015 to 30 days in 2016 in total; and
- the majority of methamphetamine users administered the drug through injections; and this method was common to all forms of methamphetamine (see Table 7).²⁸

Table 7: Proportion of people who inject drugs that reported use of crystal methamphetamine in the preceding six months, by jurisdiction, 2010–2016²⁹

%	National	NSW	ACT	Vic.	Tas.	SA	WA	NT	Qld.
2010	39	48	48	36	20	60	40	18	37
2011	45	53	57	53	26	44	46	28	50
2012	54	68	66	59	43	56	64	26	44
2013	55	74	61	55	45	57	59	30	50
2014	61	74	72	75	54	60	53	26	58
2015	67	65	79	71	59	70	64	60	62
2016	73	77	78	73	73	75	62	69	69

26 National Drug and Alcohol Research Centre (NDARC), 'Australian Drug Trends 2016: Findings from the Illicit Drug Reporting System', *Australian Drug Trends Series No. 146*, 2017, p. 1.

27 NDARC, 'Australian Drug Trends 2016: Findings from the Illicit Drug Reporting System', *Australian Drug Trends Series No. 146*, 2017, p. 19.

28 NDARC, 'Australian Drug Trends 2016, Findings from the Illicit Drug Reporting System', *Australian Drug Trends Series No. 146*, 2017, p. 19.

29 NDARC, 'Australian Drug Trends 2016: Findings from the Illicit Drug Reporting System', *Australian Drug Trends Series No. 146*, 2017, p. 21.

Clients of Alcohol and Other Drug Treatment Services

2.23 The AIHW collects data as part of the Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS NMDS). Data included in the AODTS NMDS is from treatment provided by publicly-funded AOD treatment agencies in Australia. Since 2003–04, the AIHW releases the Clients of AODTS reports.³⁰

2.24 The Clients of AODTS report for 2015–16 found that 23 per cent of closed treatment episodes³¹ had amphetamines listed as the principal or additional drug of concern.³² There were 46 441 treatment episodes for amphetamines in 2015–16, an increase³³ from 32 407 treatment episodes in 2014–15 (see Table 8).³⁴

Table 8: National closed treatment episodes for clients own drug use by principal drug of concern, 2010–2016³⁵

Year	2010–11	2011–12	2012–13	2013–14	2014–15	2015–16
Amphetamine	12 563	16 875	22 265	28 919	32 407	46 441

National Wastewater Drug Monitoring Program

2.25 On 26 March 2017, the ACIC released its first report from the National Wastewater Drug Monitoring Program (wastewater program's first report). The wastewater program was established in June 2016 after \$3.6 million was allocated from the Confiscated Assets Fund to fund it.³⁶ The wastewater program tests for 13

30 AIHW, *Alcohol and other drug treatment National Minimum Data set*, <http://www.aihw.gov.au/alcohol-and-other-drugs/data-sources/aodts-nmnds-2015-16/> (accessed 26 July 2017).

31 A closed treatment episode is when a treatment is considered closed because: it has completed or has ceased; there has been no contact with the client for three months; or there is a change in the main treatment type/principal drug of concern/or delivery setting (*See* AIHW, 'Alcohol and other drug treatments services in Australia 2014–15', *Drug Treatment Series No. 27*, 2016, p. 12).

32 AIHW, 'Alcohol and other drug treatments services in Australia 2014–15', *Drug Treatment Series No. 27*, 2016, p. 25.

33 The AIHW noted a significant increase in the number of treatment episodes from 170 367 in 2014–15 to 206 635 in 2015–16. The increase was largely due to improvements in the reporting following the underreporting of treatment episodes due to a system issue. *See* AIHW, *Clients of alcohol and other drug treatment services*, <http://www.aihw.gov.au/alcohol-and-other-drugs/data-sources/aodts-nmnds-2015-16/clients/> (accessed 26 July 2017).

34 AIHW, *Clients of alcohol and other drug treatment services 2015–16*, <http://www.aihw.gov.au/alcohol-and-other-drugs/data/#aodts-cubes> (accessed 30 July 2017).

35 AIHW, *Clients of alcohol and other drug treatment services 2015–16*, <http://www.aihw.gov.au/alcohol-and-other-drugs/data/#aodts-cubes> (accessed 30 July 2017).

36 ACIC, *National Wastewater Drug Monitoring Program*, Report 1, March 2017, p. 2.

drugs, both illicit³⁷ and licit.³⁸ The data collected captures approximately 14 million Australians (58 per cent of the population).³⁹

2.26 The wastewater program's first report argued that methamphetamine 'is the highest consumed illicit drug tested across all regions⁴⁰ in Australia'.⁴¹ Although the wastewater analysis has found methamphetamine use to be high, the exclusion of cannabis (THC)⁴² has meant this finding conflicts with some other evidence. For example, the 2013 household survey showed the most common illicit drug used both recently and over participants' lifetime was cannabis, 'used by 10.2 per cent and 35 per cent respectively of people aged 14 and over'.⁴³

2.27 The wastewater program's first report noted:

- the capital city sites in Tasmania and the Australian Capital Territory showed the lowest levels of methamphetamine in their wastewater;
- methamphetamine detections in South Australian (SA) city sites exceeded detections in SA regional sites;
- methamphetamine detections in wastewater over the past five years at the Queensland and SA sites have shown a consistent pattern of increasing levels;⁴⁴

37 Illicit drugs tested are methamphetamine, amphetamine, cocaine, 3,4-methylenedioxymethamphetamine (MDMA), 3,4-methylenedioxyamphetamine (MDA), JWH-018, JWH-073, mephedrone and methylone. Cannabis or tetrahydrocannabinol (THC) is not tested as part of the wastewater analysis.

The absence of cannabis was questioned by UnitingCare's Chief Executive Officer (CEO) Mr Laurence Alvis and Dr Stephen Bright from the NDRI, see: Mr Laurence Alvis, CEO ReGen and Dr Stephen Bright, Senior Lecturer of Addiction at Edith Cowan University and Research Fellow, NDRI. See also, 'Wastewater drug monitoring: Never let the evidence get in the way of a good story', *Media Watch*, 6 April 2017, <http://aodmediawatch.com.au/wastewater-drug-monitoring-never-let-the-evidence-get-in-the-way-of-a-good-story/> (accessed 27 July 2017).

38 Licit drugs include tobacco, alcohol, oxycodone and fentanyl.

39 The breakdown of sites by jurisdiction are: New South Wales has 10 sites; Victoria 7 sites; Queensland 12 sites; South Australia 8 sites; Tasmania 7 sites; Western Australia 4 sites; Northern Territory 2 sites and the Australian Capital Territory has one site. 22 sites are capital cities and 29 sites are regional. See, ACIC, *National Wastewater Drug Monitoring Program*, Report 1, March 2017, pp 7, 12.

40 The National Wastewater Drug Monitoring Program does not specify specific test sites; however, this information is shared confidentially with law enforcement and health agencies.

41 ACIC, *National Wastewater Drug Monitoring Program*, Report 1, March 2017, p. 3.

42 Tetrahydrocannabinol.

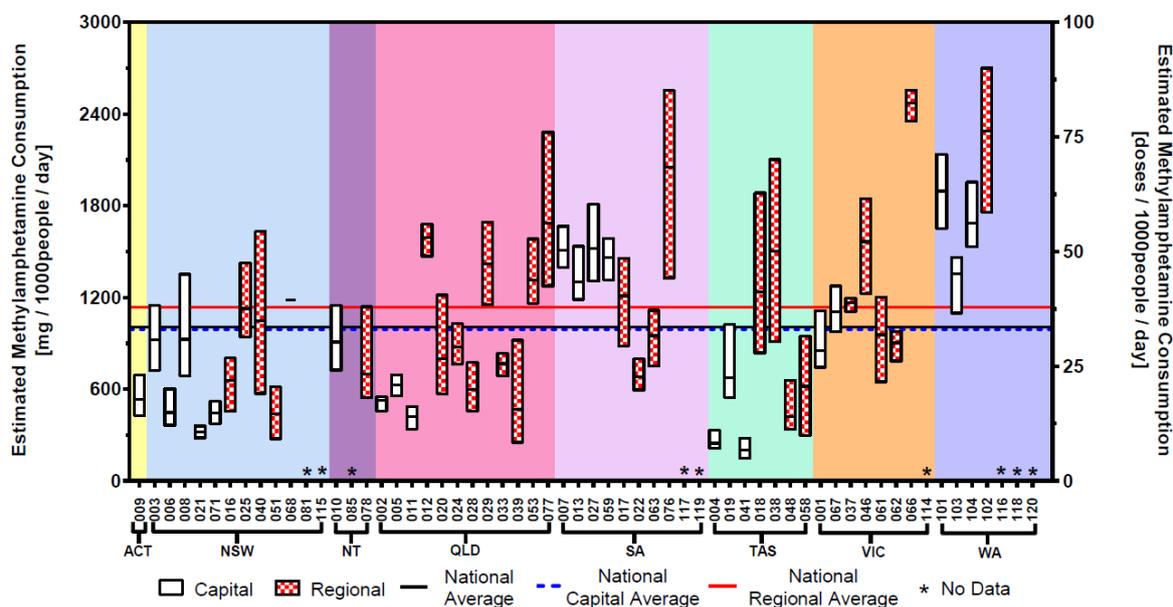
43 AIHW, *National Drug Strategy Household Survey detailed report 2013*, AIHW, p. 49.

44 Queensland and South Australia were included in a pilot program and therefore have longitudinal analysis available.

- Western Australia (WA) has the highest levels of methamphetamine in its wastewater, with detection in both city sites and regional sites far exceeding the national average;
- several regional sites in Queensland, Victoria and Tasmania show high levels of methamphetamine detection; and
- Australia ranks second out of 18 countries for consumption of methamphetamine (Slovakia is ranked first).⁴⁵

2.28 Figure 1 is extracted from the wastewater program's first report. It shows the estimated amount of methamphetamine consumption per thousand people and doses per day at each of the testing sites. Data is separated by state and territory and by capital region and regional area. Finally, the figure indicates both national capital average and regional average (the red and blue lines). The figure shows regional consumption rates in WA, SA and Queensland are far higher than the national regional average. Data from WA and SA show above average consumption in capital areas.

Figure 1: Estimated methamphetamine consumption in mass consumed per day (left axis) and doses per day (right axis) per thousand people. The number of collection days varied from 1–7⁴⁶



2.29 The national wastewater program complements other wastewater analysis, such as the University of South Australia's Drug use in Adelaide Monitored by Wastewater Analysis reports (SA analysis), commissioned by the Drug and Alcohol Services South Australia. This analysis commenced in 2011 and focuses on

45 ACIC, *National Wastewater Drug Monitoring Program*, Report 1, March 2017, p. 3.

46 ACIC, *National Wastewater Drug Monitoring Program*, Report 1, March 2017, p. 26.

metropolitan Adelaide. Unlike the national program, the SA wastewater analysis includes heroin⁴⁷ and cannabis.⁴⁸

2.30 The SA analysis for April 2017 showed methamphetamine use in metropolitan Adelaide slowly increasing between 2012 and December 2016. However, there has been a steady decline during the reporting periods for 2017.⁴⁹

2.31 On 27 July 2017, the ACIC released the wastewater program's second report. This second wastewater report found that methamphetamine remained the highest consumed illicit drug tested across all regions; however, nationally there has been a slight reduction in methamphetamine detections when compared to the first reporting period.⁵⁰ Testing sites in the Northern Territory (NT) and Tasmania⁵¹ did not participate⁵² in the second reporting period.⁵³

2.32 The second wastewater report found detections were highest in SA and WA.⁵⁴ For both these states, use appears to have peaked in October 2016 and has subsequently declined since. Queensland shows a similar pattern, although less pronounced.⁵⁵ The ACIC concluded that:

47 The ACIC announced in its second waste water analysis report that heroin will be tested in future analyses. See, ACIC, *National Wastewater Drug Monitoring Program*, Report 2, July 2017, p. 10.

48 University of South Australia, *Drug use in Adelaide Monitored by Wastewater Analysis*, April 2017, p. 6, http://www.sahealth.sa.gov.au/wps/wcm/connect/f801a20045027e445f4005ba75f87/Standard+report+December+2016+data_16+03+17.pdf?MOD=AJPERES&CACHEID=f801a20045027e445f4005ba75f87 (accessed 27 July 2017).

49 University of South Australia, *Drug use in Adelaide Monitored by Wastewater Analysis*, April 2017, p. 6, http://www.sahealth.sa.gov.au/wps/wcm/connect/f801a20045027e445f4005ba75f87/Standard+report+December+2016+data_16+03+17.pdf?MOD=AJPERES&CACHEID=f801a20045027e445f4005ba75f87 (accessed 27 July 2017).

50 ACIC, *National Wastewater Drug Monitoring Program*, Report 2, July 2017, p. 6.

51 On 27 July 2017, TasWater denied it opted out of the wastewater analysis. See: Edith Bevin, 'TasWater denies it has opted out of "vital" wastewater testing for drugs like ice', *ABC*, 27 July 2017, <http://www.abc.net.au/news/2017-07-27/taswater-denies-opt-out-from-national-sewage-drug-testing/8748620> (accessed 31 July 2017).

52 The ACIC noted if further testing sites decide to not participate in the national wastewater analysis, the ACIC will identify replacement sites in participating jurisdictions to ensure the largest possible segment of the national population is sampled. The ACIC noted the location of sites may change over the three years of the study. See, ACIC, *National Wastewater Drug Monitoring Program*, Report 2, July 2017, p. 10.

53 ACIC, *National Wastewater Drug Monitoring Program*, Report 2, July 2017, p. 4.

54 ACIC, *National Wastewater Drug Monitoring Program*, Report 2, July 2017, p. 24.

55 ACIC, *National Wastewater Drug Monitoring Program*, Report 2, July 2017, p. 24.

The overall picture for methylamphetamine is one of ongoing and strong demand. While the National Wastewater Drug Monitoring Program has shown signs that consumption may have peaked in late 2016, it is too early to say with any certainty if this recent reduction in consumption is the start of a longer term trend.⁵⁶

Problematic versus non-problematic use

2.33 Despite the number of users and the negative effects of crystal methamphetamine use, numerous submitters and witnesses advised the committee that the majority of individuals who use the drug do not demonstrate problematic use (such as anti-social or criminal behaviour) and live normal and productive lives. Further, although crystal methamphetamine impacts on a wide range of individuals from across Australia, there are particular communities and groups that are more at risk of developing problematic crystal methamphetamine use.

2.34 The Australian Injecting and Illicit Drug Users League observed that a small minority of people, approximately 15 per cent, use crystal methamphetamine on a regular or daily basis. The remaining '85 per cent are engaging in more irregular or occasional use, and perhaps less problematic use—that is, less than weekly and, for most, less than monthly'.⁵⁷

2.35 The Australian Federation of AIDS Organisations described the majority of crystal methamphetamine users as non-problematic, that is:

...problematic in being contrary to criminal law but not necessarily problematic in terms of health use. However, we do acknowledge that for some people there are problematic levels of ice use...[it is] [n]ot problematic in terms of being able to function.⁵⁸

2.36 Dr Alex Wodak, President of the Australian Drug Law Reform Foundation (ADLRF) commented on the differences between problematic and non-problematic use of crystal methamphetamine. Referring to a series of longitudinal studies for cocaine and amphetamine, Dr Wodak stated that people who consume 'impressive quantities' of these drugs 'never came to the attention of law enforcement or health services for their drug problem' and '[w]hen they started getting some difficulties, they managed to work out how to pull themselves back'.⁵⁹ Further, Dr Wodak argued that:

...although it does not seem to be something that we would leap at believing, the evidence is fairly clear that some people are able to use

56 ACIC, *National Wastewater Drug Monitoring Program*, Report 2, July 2017, p. 43.

57 Ms Annie Madden, Executive Officer, Australian Injecting and Illicit Drug Users League, *Committee Hansard*, 25 November 2015, p. 7.

58 Ms Linda Forbes, Manager, Policy and Communications, Australian Federation of AIDS Organisation, *Committee Hansard*, 29 July 2015, p. 15.

59 Dr Alex Wodak, President, Australian Drug Law Reform Foundation (ADLRF), *Committee Hansard*, 29 July 2015, p. 49.

powerful psychoactive substances for long periods and monitor their own behaviour to a surprising degree. That is not to say that that is recommended. I do not recommend it and I am not calling for people to do that, clearly. I spent the last 30 years dealing with people who got into serious trouble—some died—caused great misery and anxiety to their families, caused great pain and suffering in the community generally and were struggling with psychoactive drug use. So I am not a fan of people getting into trouble with drugs, but we have to acknowledge the truth, and the truth is: yes, some people can manage to consume significant quantities of these drugs and somehow not get into trouble.⁶⁰

...people who used large quantities of drugs and started to have some difficulty pulled themselves up. They would say, 'I'm not going to take any cocaine for three months,' or six months, or 'I'm only going to take it on weekends,' or 'I'm not going to spend more than \$30 a day on it.' They made up some rule and stuck to it. After they got it under control, they would go back. A lot of people monitor their own behaviour in other areas in a similar way. We have to remember that a lot of people who have problems with psychoactive drugs in the community do get better by themselves. There is a lot of resilience in human beings.⁶¹

2.37 Although problematic crystal methamphetamine use may not eventuate for all users, the Penington Institute highlighted that problematic use can adversely affect 'people from all backgrounds and from all geographic areas' and:

...the spread of ice use in Australia has proven that drugs are available in country areas—in regional and rural and even remote areas—just as much as they are in the big cities. We have heard stories of the landed big farming families—very well-to-do families—having problems with ice in their own families, right down to the most socially disadvantaged and marginalised communities. The people that get addicted and cause most of the problems typically have pre-existing mental health issues like depression or anxiety, and sometimes for those people ice is the first time they have ever experienced great pleasure in their life. So they go back to it, and sooner rather than later they are addicted.⁶²

Young people

2.38 Evidence presented to the committee identified young people as being more likely to use crystal methamphetamine and at greater risk of problematic use. The household survey for 2013 showed that 41 per cent of people between the ages of 20 and 29 years identified amphetamine as their principal drug of concern⁶³ when seeking

60 Dr Wodak, ADLRF, *Committee Hansard*, 29 July 2015, p. 49.

61 Dr Wodak, ADLRF, *Committee Hansard*, 29 July 2015, p. 50.

62 Mr John Ryan, CEO, Penington Institute, *Committee Hansard*, 27 July 2015, p. 10.

63 The primary drug that leads an individual to seek treatment is identified because users often report poly-drug use. Poly-drug use is discussed further in this chapter (see paragraph 2.117–2.118).

treatment.⁶⁴ Amphetamine was identified as an additional drug of concern for 36 per cent of people aged between 20 and 29 years who sought treatment during the surveyed period.⁶⁵

2.39 Professor Rebecca McKetin, at the time based at the Australian National University, warned the committee that the uptake of crystal methamphetamine amongst young people is an indicator of the beginning of an epidemic.⁶⁶ Further, Professor McKetin advised that trends show there has been a 'doubling of the number of heavy users' of crystal methamphetamine and the 'increase was strongest in the under-24 age group'.⁶⁷ Although heavy use had increased for people aged 24 or under, the bulk of users are people in their 30s.⁶⁸

2.40 The committee heard anecdotal evidence from staff involved in front line treatment of problematic use that there has been an increase in the number of young people seeking crystal methamphetamine treatment. A particular concern of Queensland Health was the early age of people initiating the use of crystal methamphetamine. Historically, those entering treatment programs were 17 or 18 years old, but Queensland Health staff expressed concern that they are now seeing 15 and 16 year olds coming through their service.⁶⁹ Kidz Youth Community Consultancy advised that it has provided treatment for children as young as 10 and that adolescents and young people who are experimenting with crystal methamphetamine are:

...unfortunately more inclined to become [dependent]. It is one of the characteristics we are seeing with [crystal methamphetamine]. For our service, probably about 40 per cent of the young people are staying on it quite heavily, whereas others may binge use and then stop using for a little while and then binge use, depending on availability and also on whether there are other drugs around at the time.⁷⁰

2.41 Research by Professor Louisa Degenhardt et al published in the *Medical Journal of Australia* indicates that the number of dependent and regular users of methamphetamine in Australia has increased since 2010, especially in the 15–24 and 25–34 age groups. The research found:

Rapid uptake of methamphetamine use may still be occurring outside the largest cities, especially in regional centres where young people without

64 AIHW, *Submission 6*, p. 5.

65 AIHW, *Submission 6*, p. 5.

66 See paragraph 2.41.

67 Professor Rebecca McKetin, Australian National University (ANU), *Committee Hansard*, 9 September 2015, p. 11.

68 Professor McKetin, ANU, *Committee Hansard*, 9 September 2015, p. 11.

69 Mrs Emma Armitage, Allied Health Manager, Queensland Health, *Committee Hansard*, 30 July 2015, p 22.

70 Ms Kim Reid, Executive Director, Kidz Youth Community Consultancy, *Committee Hansard*, 30 July 2015, p. 22.

prior experience of methamphetamine may be exposed to it. The available data, together with findings reported in this article, suggest a sharp increase in problematic methamphetamine use among particular subgroups (particularly young people) in Australia.⁷¹

2.42 Other factors relating to the uptake of crystal methamphetamine among young people include its availability and affordability (discussed further at paragraph 2.105–2.107) and whether those using the drug are a member of one of the vulnerable categories described in the following sections.

Regional and rural communities

2.43 The committee heard that regional and rural communities are particularly vulnerable to problematic crystal methamphetamine use. According to the AIHW, people living in remote and very remote regions 'were at least twice as likely to have used meth/amphetamines in the previous 12 months as people living in Major cities and Inner regional areas'.⁷²

2.44 Table 9 outlines data provided by the AIHW demonstrating differences in meth/amphetamine use between those located in major cities compared with those in regional and remote areas.

71 Louisa Degenhardt, Sarah Larney, Gary Chan, Timothy Dobbins, Megan Weier, Amanda Roxburgh, Wayne Hall and Rebecca McKetin, 'Estimating the number of regular and dependent methamphetamine users in Australia, 2002–2014', *Medical Journal of Australia* 2014 (4), 7 March 2016, p. 1.e4.

72 AIHW, *Submission 6*, p 4.

Table 9: Meth/amphetamine use, people aged 14 years or older, by remoteness area (2007 to 2013)⁷³

Remoteness/Year	Ex-users ⁷⁴			Recent users ⁷⁵		
	2007	2010	2013	2007	2010	2013
Major cities	3.9	5.1	4.3	2.5	2.0	2.1
Inner regional	3.2	4.1	4.1	1.7	2.0	1.6
Outer regional	4.1	4.4	4.0	1.6	1.5	2.0
Remote/very remote	5.7	7.2	8.6	3.0	4.0 ⁷⁶	4.4 ⁷⁷

2.45 The ACIC's wastewater program similarly highlighted differences in methamphetamine use between capital and regional sites across Australia. The program's first report shows WA with the highest levels of methamphetamine, in both capital and regional areas.⁷⁸ Regional areas had higher levels of methamphetamine use compared to capital sites, except for SA and the NT.⁷⁹

2.46 Figure 2 is extracted from the wastewater program's first report. It shows the estimated amount of methamphetamine consumption per thousand people and doses per day. Data is separated between capital and regional areas, and by state and territory. The figure shows both the national capital average and regional average. Regional consumption in SA, Victoria and WA is above the national average. WA and SA have higher average consumption of methamphetamine than other state and territories.

73 AIHW, *Submission 6*, p 9.

74 Users that had not used crystal methamphetamine in the previous 12 months.

75 Used within the previous 12 months.

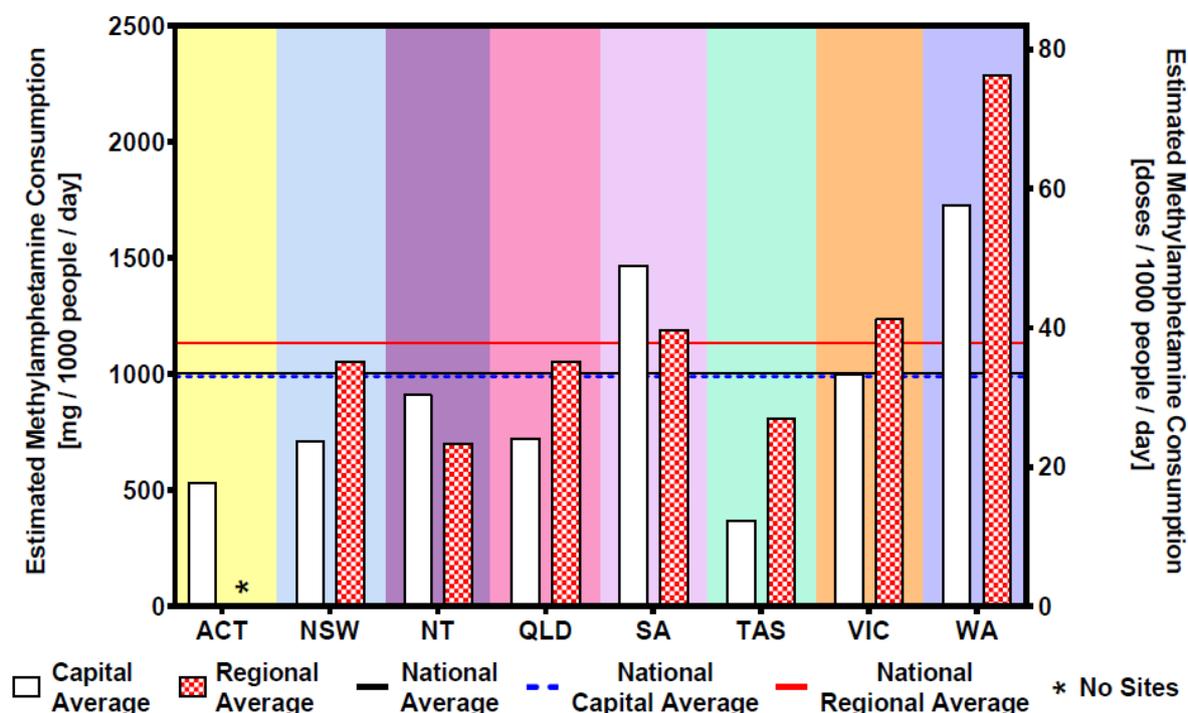
76 The NDSHS noted that this estimate has a relative standard error of 25 per cent and 50 per cent and should be used with caution.

77 The NDSHS noted that this estimate has a relative standard error of 25 per cent and 50 per cent and should be used with caution.

78 Western Australia had only one regional testing site included in the report.

79 ACIC, *National Wastewater Drug Monitoring Program*, March 2017, p. 35.

Figure 2: Estimated average consumption of methamphetamine for capital city sites and regional sites by state/territory⁸⁰



2.47 According to the National Rural Health Alliance's *Illicit Drug use in Rural Australia* report, the causes of illicit drug use in rural and remote areas are multiple and inter-related: '[d]istance and isolation, poor or non-existent public transport, a lack of confidence in the future and limited leisure activities all contribute to illicit drug use in rural communities'.⁸¹

2.48 The unique challenges faced by regional and rural communities were raised by a number of submitters and witnesses. Professor Ann Roche from Flinders University observed that regional and rural communities are more 'likely to experience greater levels of consumption of alcohol and have associated problems with alcohol' and that '[h]igher levels of most illicit substances tend to concentrate where they have access to these drugs in regional and rural areas'.⁸² The reason, according to Professor Roche, is that at a social level:

...where you have communities where there are higher levels of unemployment and social disadvantage and higher levels of depression and mental health problems, as you often get in many regional and rural

80 ACIC, *National Wastewater Drug Monitoring Program*, March 2017, p. 35.

81 National Rural Health Alliance, *Illicit Drug Use in Rural Australia, Fact Sheet 33*, June 2015, p. 1.

82 Professor Ann Roche, Director, National Centre for Education and Training on Addiction, Flinders University, *Committee Hansard*, 28 July 2015, p 4.

communities, and fewer life opportunities the individuals in those communities are more vulnerable to the use of substances that are basically going to make them feel better when life is not looking particularly good.⁸³

2.49 She argued that this issue must be a major consideration for government when forming appropriate response strategies to problematic drug use in those communities.⁸⁴

2.50 Another significant issue facing people in regional and rural areas is accessing treatment services. According to the Victorian Alcohol and Drug Association (VAADA), individuals from regional and rural communities have less access to health services, including both primary health and AOD treatments. Primary health care is limited in regional and rural areas with 3.6 general practitioners available per 10 000 head of population, compared to 7.6 general practitioners per 10 000 in metropolitan areas.⁸⁵ Distance, privacy, availability, and simple staffing of services all create barriers for those in rural communities to access AOD treatments.⁸⁶

2.51 A further hurdle facing people from regional and rural communities, as described by the Australian Psychological Society (APS), is that once users return to the 'real world' after seeking treatment, they can find themselves back in their community 'where everyone is using and [they] are not'. Those trying to recover from addiction are:

...discharged back to [their] community where there is nothing. [They] can go from seeing a counsellor every day or once a week in a very supportive community to being discharged back to [a] community in some regional place where [they] will get no access to any support at all.⁸⁷

2.52 As discussed above, a number submitters and witnesses stated that people from regional and rural communities are at a higher risk of developing problematic crystal methamphetamine use. By contrast, others suggested that this was not necessarily the case. For example, Drug Arm Australasia argued that its data does not indicate a 'real difference in presentation rates' between metropolitan and regional and remote areas. The problem was instead the visibility of those people using crystal methamphetamine because 'in a metro region you have the dilution effect that you do not have in a regional area'.⁸⁸

83 Professor Roche, Flinders University, *Committee Hansard*, 28 July 2015, pp 4–5.

84 Professor Roche, Flinders University, *Committee Hansard*, 28 July 2015, pp 4–5.

85 Victorian Alcohol and Drug Association (VAADA), *Submission 14*, p. 8.

86 VAADA, *Submission 14*, p. 9.

87 Dr Louise Roufeil, Executive Manager Professional Practice, Australian Psychological Society, *Committee Hansard*, 27 July 2015, p. 54.

88 Ms Jody Wright, Executive Officer, Drug Arm Australasia, *Committee Hansard*, 30 July 2015, p. 6.

2.53 Professor Paul Dietze, the Deputy Director of the Burnet Institute, indirectly supported Drug Arm Australasia's comments. He informed the committee that although there was sufficient anecdotal evidence describing the negative effects of methamphetamine related problems in regional and remote communities:

...whenever we look closely at those reports, there is really not much evidence to support them in terms of some of the indicator data that are there. When I talk about indicator data, I mean things like ambulance attendances and so forth.⁸⁹

2.54 The problem, as detailed by Professor Dietze, is not necessarily that there is no problem with crystal methamphetamine use in regional and rural communities, but there is 'very little reasonable data from regional Australia'⁹⁰ and for this reason:

We do not really have a good picture of what is going on...We really have not made an investment in trying to find out what is actually going on, either. We need to be moving beyond anecdote in relation to these parts of the country.⁹¹

Indigenous communities

2.55 The committee heard that Australia's Indigenous communities are at a higher risk of developing problematic crystal methamphetamine use. Indigenous communities share the same vulnerabilities as other people found in regional and remote communities;⁹² however, these vulnerabilities are more complex due to other factors such as the 'disparity in the general health of Aboriginal Australians compared to non-Indigenous Australians'⁹³ and the imprisonment rates of Indigenous people being '14 times higher than the rate of non-Indigenous population'.⁹⁴ The National Aboriginal & Torres Strait Islander Legal Service said that Indigenous communities 'are at a higher risk of complex trauma because of the legacy of colonisation, stolen generation policies, loss of land and ongoing racism and discrimination which places them at greater risk of drug abuse'.⁹⁵

2.56 The AIHW reported that 'Aboriginal and Torres Strait Islander people were 1.5 times⁹⁶ more likely to have recently used meth/amphetamine than non-Indigenous

89 Professor Paul Dietze, Deputy Director, Burnet Institute, *Committee Hansard*, 9 September 2015, p. 5.

90 Professor Dietze, Burnet Institute, *Committee Hansard*, 9 September 2015, p. 5.

91 Professor Dietze, Burnet Institute, *Committee Hansard*, 9 September 2015, p. 4.

92 Miss Laura McGillivray, Bond University, *Committee Hansard*, 30 July 2015, p. 39.

93 Youth Off the Streets, *Submission 33*, p. 6.

94 Youth Off the Streets, *Submission 33*, p. 6.

95 National Aboriginal & Torres Strait Islander Legal Service, *Submission 69*, p 5.

96 The AIHW reported that this estimate had a relative standard error of between 25 per cent and 50 per cent, and therefore should be interpreted with caution.

people'.⁹⁷ However, Youth Off the Streets was concerned that research into Indigenous communities and drug use has been primarily focused on Indigenous people in urban areas and there is limited data on usage rates for Indigenous peoples in regional and remote areas.⁹⁸ According to a 2012–13 National Australian Aboriginal and Torres Strait Islander Health Survey, 2.7 per cent of Indigenous Australians living in non-remote areas reported the use of speed or amphetamine in the past year.⁹⁹

2.57 The NT Police told the committee that there are a small number of known Indigenous meth/amphetamine users in the NT and that these users are largely from urban centres. The NT police also advised that there is use in some remote communities¹⁰⁰ but that it is not widespread.¹⁰¹ The Cape York Health Council commented that across Cape York there is 'probably only about 18 or so methamphetamine users' but the number of crystal methamphetamine users is unknown. The Health Council further remarked that 'people know it is around and report it, but [health services] are not seeing the worst effects of [crystal methamphetamine] coming into the health services as yet'.¹⁰² The Cape York Partnership said that 'regions like Cape York are very vulnerable to drugs like ice' and therefore its representatives were:

...very concerned about this drug and its potential consequences. But it is 'potential'. We are not saying that ice is prevalent in use or consequences at this stage in Cape York, thankfully.¹⁰³

2.58 Overall, the committee was made aware of a heightened level of concern amongst Indigenous communities about the risk posed by crystal methamphetamine and the proactive approach taken by some communities. Dr Pendo Mwaiteleke from the Cape York Partnership said that there had been a summit of:

...200 community leaders and representatives. One of the themes that came across really strongly was that there is actually a growing culture within the community and community leaders that they do not want ice in the community and are trying to do everything to make sure that ice does not come in. At the same time, there are some anecdotes that there have been some attempts to bring ice into some communities. I made a visit to Aurukun. The community is very strong. I spoke to quite a number of people, and everyone I spoke to was very anti-ice. There was a feeling that, if ice were to get into the community, it is going to be devastating. 'We are

97 AIHW, *Submission 6*, p. 4.

98 Youth Off the Streets, *Submission 33*, p. 7.

99 Bond University, *Submission 70*, p. 10.

100 Reported occurrences were in East Ernhem and Tiwi Island regions.

101 Northern Territory Police, *Submission 68*, pp 11–12.

102 Dr Mark Wenitong, Cape York Health Council, *Committee Hansard*, 30 July 2015, p. 15.

103 Mr Brian Stacey, Cape York Partnership, *Committee Hansard*, 30 July 2015, p. 18.

trying to solve the problems that we have; so, if we do not stand up to make sure that ice is not brought to our community, we know there are going to be very serious ramifications'.¹⁰⁴

2.59 The WA Primary Health Alliance informed the committee that there are two principal concerns regarding crystal methamphetamine use in Indigenous communities. Firstly, younger Indigenous people are more likely to develop dependency issues; and secondly, high rates of crystal methamphetamine being administered intravenously.¹⁰⁵ As noted above, longitudinal studies confirm that these issues are mirrored in the Australian population more broadly. However, the evidence indicates that these issues, combined with the challenges faced by Indigenous communities, increases the impacts of crystal methamphetamine use on young Indigenous people.

2.60 The Aboriginal Health Council of Western Australia, when asked whether crystal methamphetamine use more prevalent in Indigenous communities, responded:

Throughout a number of consultations that we have undertaken with our sectors, we have seen the shift and we have seen the impacts that methamphetamines have. It has had an empowering or overwhelming effect on, particularly, our younger generations. However, it is a combination of alcohol and methamphetamine usage. Whilst there has been evidence provided that alcohol use is still higher than methamphetamine use, in our opinion, looking at it from the Aboriginal community perspective, we see methamphetamine use overpowering alcohol use. One of the things that we have been adamant about is that just focusing on methamphetamine use is not going to have a dramatic impact, because we need to also deal with the social impacts for these young people who actually have that urge to sample that particular drug.¹⁰⁶

Lesbian, gay, bisexual, transgender and intersex community

2.61 Another community that presents with higher use of crystal methamphetamine is the lesbian, gay, bisexual, transgender and intersex (LGBTI) community. The AIHW reports that people who identify as homosexual or bisexual are 4.5 times more likely to use methamphetamine than people in the general population.¹⁰⁷

2.62 The 2016 Sydney Gay Community Periodic Survey reports that since 2012 there has been a significant decline in the use of crystal methamphetamine, although HIV positive men are disproportionately more likely to report using the substance.¹⁰⁸

104 Dr Pendo Mwaiteleke, Cape York Partnership, *Committee Hansard*, 30 July 2015, pp 15–16.

105 Ms Learne Durrington, CEO, WA Primary Health Alliance, *Committee Hansard*, 2 May 2017, p. 18.

106 Ms Michelle Nelson-Cox, Chairperson, Aboriginal Health Council of Western Australia, *Committee Hansard*, 3 May 2017, p. 44.

107 AIHW, *National Drug Strategy Household Survey detailed report 2013*, p. 95.

108 University of New South Wales (UNSW), *Gay Community Periodic Survey: Sydney 2016*, p. 5.

Of the 3015 men surveyed, 10.4 per cent reported use of crystal methamphetamine, down from the 11.5 per cent (2846 respondents) in 2015.¹⁰⁹

2.63 The 2016 Gay Community Periodic Survey for Melbourne reported that crystal methamphetamine use amongst Melbourne's gay population had remained stable.¹¹⁰ In 2016, 9.9 per cent of the 2886 respondents reported using crystal methamphetamine, lower than the 11.4 per cent (3 006 respondents) in 2015.¹¹¹

2.64 The AIDS Council of New South Wales advised the committee that LGBTI people may use drugs:

...for similar reasons as the general populations, the ways in which this use plays out can be very different for people in [LGBTI] communities. There is a significant association between the use of methamphetamine and sex, and that use can impact negatively on sexual health and HIV, both in terms of transmission and treatment adherence. This association is very complicated and is worthy of dedicated and specific government attention.¹¹²

2.65 The Penington Institute reported that HIV positive men who have sex with men (MSM) and use crystal methamphetamine are 'more likely to report high-risk sexual behaviours such as unprotected anal intercourse, compared to HIV positive MSM who do not use ice'.¹¹³ The use of drugs such as crystal methamphetamine during sex has become commonly known as 'chemsex' and is a growing sub-culture within the Australian LGBTI community.¹¹⁴

2.66 Although use of crystal methamphetamine in the LGBTI community is significantly higher than the general population, its use is not as visible, and as a result of this lack of visibility:

...its use and impacts are often more private and hidden. Despite this lack of visibility, the impacts can be just as great. They can include loss of careers, relationship stress and domestic and family violence, but rarely do they manifest in the displays of public aggression or dysfunction that play out in other sections of the community.¹¹⁵

109 UNSW, *Gay Community Periodic Survey: Sydney 2016*, p. 21.

110 UNSW, *Gay Community Periodic Survey: Melbourne 2016*, p. 7.

111 UNSW, *Gay Community Periodic Survey: Melbourne 2016*, p. 23.

112 Mr Nicolas Parkhill, CEO, AIDS Council of New South Wales, *Committee Hansard*, 29 July 2015, p. 16.

113 The Penington Institute, *Submission 26*, p 21.

114 Imogen Brennan, 'Sex and crystal meth: The rise of chemsex', *ABC Lateline*, <http://www.abc.net.au/news/2016-04-14/the-rise-of-chemsex/7326744> (accessed on 13 September 2016).

115 Mr Parkhill, AIDS Council of New South Wales, *Committee Hansard*, 29 July 2015, p. 16.

The mental and physical effects of crystal methamphetamine

2.67 Amphetamine and methamphetamine have similar effects; however differences in the chemical structure of methamphetamine increase its potency.¹¹⁶ The short term mental effects of use may include:

- anxiety;
- fatigue;
- irritability;
- hallucinations;
- suppressed appetite; and
- insomnia.¹¹⁷

2.68 Long term mental effects may include:

- memory loss;
- decision making impairment;
- drug dependency;¹¹⁸ and
- depression, anxiety and psychosis.¹¹⁹

2.69 In the short term, the physiologically the effects of crystal methamphetamine on the body include:

- an increase in the user's heart rate;
- hypertension; and
- constriction of blood vessels.¹²⁰

2.70 In the long term, the physical effects include:

- an increased risk of stroke;
- potential for ruptured blood vessels in the brain;
- decreased lung function;
- poor dental health;¹²¹
- weight loss;

116 ACIC, *Illicit Drug Data Report 2014–15*, p. 24.

117 ACIC, *Illicit Drug Data Report 2014–15*, p. 24.

118 ACIC, *Illicit Drug Data Report 2014–15*, p. 24.

119 The National Centre for Education and Training on Addiction (NCETA), *Submission 27*, Attachment 1, p. 1.

120 NCETA, *Submission 27*, Attachment 1, p. 1.

121 NCETA, *Submission 27*, Attachment 1, p. 1.

- skin problems; and
- sleep problems.¹²²

2.71 In addition to the negative effects listed above, submitters noted that of particular public concern are psychotic episodes and violent behaviour induced by the use of crystal methamphetamine. These are discussed in greater detail in the following sections.

Methamphetamine-induced psychosis

2.72 As highlighted by the Australian Drug Foundation (ADF), one of the more serious health impacts of chronic methamphetamine¹²³ use is psychosis. The symptoms of psychosis include confusion, delirium and panic, which can be accompanied by a range of hallucinations.¹²⁴ The ADF told the committee that users of methamphetamine are:

- 11–12 times more likely to experience psychosis than the general population;
- 23 per cent more likely to experience clinically significant psychotic symptoms of suspiciousness, hallucinations or delusions; and
- where they are dependent on methamphetamine, three times more likely than their non-dependent peers to have experienced psychotic symptoms.¹²⁵

2.73 A common manifestation of methamphetamine-induced psychosis is the delusion of insect and/or parasite infestations under the user's skin.¹²⁶

2.74 Professor McKetin explained that one risk associated with methamphetamine use is an acute psychosis that manifests as transient paranoia and 'when people are using this drug, their risk of that paranoid state increases five-fold from when they are not using the drug'.¹²⁷ A further risk is that transient psychosis for a minority of people can trigger a more chronic psychological problem. However, there is less evidence to support this idea and researchers 'do not know whether it has triggered schizophrenia because they are already predisposed to schizophrenia, or whether it is just a prolonged episode of methamphetamine psychosis that will eventually go away'.¹²⁸ Professor McKetin estimated that 20 per cent of users who have transient psychosis will form some kind of chronic symptoms.¹²⁹

122 Australian Drug Foundation (ADF), *Submission 51*, p 7.

123 Including crystal methamphetamine.

124 ADF, *Submission 51*, p 7.

125 ADF, *Submission 51*, p 7.

126 Australian Medical Association, *Submission 39*, p 2.

127 Professor McKetin, ANU, *Committee Hansard*, 9 September 2015, p. 15.

128 Professor McKetin, ANU, *Committee Hansard*, 9 September 2015, p. 15.

129 Professor McKetin, ANU, *Committee Hansard*, 9 September 2015, p. 15.

2.75 A paper published by the National Drug and Alcohol Research Centre (NDARC) in 2005 examined the Sydney methamphetamine market and reported that psychotic episodes tend to last up to three hours and only 11 per cent of those people who suffer psychosis attend hospital. Those people who attend hospital were 'more likely to have more severe long lasting symptoms'.¹³⁰ Of those users that displayed symptoms of psychosis, half felt 'hostile or aggressive at the time, and one quarter of methamphetamine users exhibited overt hostile behaviour while they were psychotic, such as yelling at people, throwing furniture or hitting people'.¹³¹

2.76 In addition to psychosis, methamphetamine can have a long-term effect on the cognitive function of users. Professor Roche said that it has a more damaging effect 'than many other drugs' and:

...within a very short period of time it can severely impact on your ability to think clearly and function, and it can take one to two years to regain that normal cognitive functioning that you had previously. That is one of the very severe potential outcomes of methamphetamine use.¹³²

Violent behaviour

2.77 A significant concern for those in regular contact with crystal methamphetamine users is severe aggression. Many representatives from law enforcement agencies and frontline health and welfare services reported incidences of violent behaviour to the committee.

2.78 The Victoria Police observed that some users of crystal methamphetamine can become quite violent and that police have seen violent behaviour 'play out in the street' between dealers and users. In comparison, those addicted to heroin 'did not resort to the level of violence that [users] do with [crystal methamphetamine]'.¹³³ Victoria Police qualified 'that [the] demeanour of the individual probably enhances it, but violence is a factor that [police] see in a lot of individuals'.¹³⁴

2.79 The Penington Institute informed the committee that people in the family violence sector have reported extreme levels of violence associated with crystal methamphetamine use. The problem, therefore:

130 Rebecca McKetin, Jennifer McLaren and Erin Kelly, 'The Sydney methamphetamine market: Patters of supply, use, personal harms and social consequences', *Monograph Series No. 13*, NDARC, 2005, p. xviii.

131 Rebecca McKetin, Jennifer McLaren and Erin Kelly, 'The Sydney methamphetamine market: Patters of supply, use, personal harms and social consequences', *Monograph Series No. 13*, NDARC, 2005, p. xviii.

132 Professor Roche, Flinders University, *Committee Hansard*, 28 July 2015, p. 7.

133 Mr Stephen Fontana, Assistant Commissioner, Victoria Police, *Committee Hansard*, 27 July 2015, p. 2.

134 Mr Fontana, Victoria Police, *Committee Hansard*, 27 July 2015, p. 2.

...is that the connection between violence and ice is much more complex than only those people who are addicted or only those people with a severe problem. It could be people in their first period of use or it could be someone with an extreme problem'.¹³⁵

2.80 The issue of domestic violence was highlighted by the NDARC, which argued that the discussion about crystal methamphetamine-related violence has to date primarily focused on random acts of violence in areas such as Kings Cross. However, little consideration has been given to domestic violence especially in concert with alcohol. The NDARC said that it was rare to have an individual that has taken only one drug and:

If you get a combination of alcohol with crystal methamphetamine in a certain person who has a propensity for rage than you are going to find yourself in a very difficult situation. So I think it is probably not as simple as talking about one drug versus another drug. I think you get this combination in people, and I think that combination or the effect of that combination behind closed doors is unseen. We see the street assaults; we do not see the family violence. I think that, for that very reason, we need to focus more attention.¹³⁶

2.81 Other submitters and witnesses cautioned against over-emphasising violence associated with crystal methamphetamine use. In particular, a number of submitters and witnesses highlighted that while crystal methamphetamine is a dangerous drug that has significant health and social impacts on individuals and communities, alcohol is a far bigger problem. For example, Professor Roche stated that there are difficulties quantifying a greater propensity to violence among users of crystal methamphetamine and that a number:

...of substances can induce more aggressive and violent behaviours. Certainly you see it with the stimulants—say, with methamphetamine—but we also see it with some individuals with alcohol as well. We have exceptionally high levels of alcohol related violence in our community. We do not have good data that can compare one group using alcohol and being violent compared to people being intoxicated with methamphetamine. In both instances they both become cognitively impaired and so their judgement is really affected. With methamphetamine you have an elevated threat response. So often it is not an issue of somebody wanting to behave in a violent and aggressive way. The drug affects the brain in such a way that they cannot form appropriate and accurate judgements about what is happening around them and they feel very threatened and then often can lash out. People do behave quite differently and it can manifest in violent behaviour in a way that is different from other substances.¹³⁷

135 Mr Ryan, Penington Institute, *Committee Hansard*, 27 July 2015, p. 12.

136 Dr Lucy Burns, NDARC, *Committee Hansard*, 29 July 2015, p. 25.

137 Professor Roche, Flinders University, *Committee Hansard*, 28 July 2015, p 7.

2.82 Similarly, the APS opined that crystal methamphetamine is a problem, however:

...alcohol is probably an even greater problem. We are talking about a very low incidence. I loved reading that submission from Emergency Medicine pointing out that the number of more serious acute aggressive episodes in emergency departments are not due to ice, they are due to people with alcohol. It is just that the people with alcohol eventually fall asleep on you and the person with ice does not. At the moment, we are certainly seeing sensationalism in this, but alcohol is significantly more problematic than ice for emergency departments, police and families.¹³⁸

2.83 Indeed, Dr Wodak advised that:

The violence we see from alcohol at St Vincent's Hospital and at every emergency department in every hospital throughout the country is colossal. Every Thursday night, every Friday night and every Saturday night if you go to any emergency department in the country between 9 pm and 3 am it is mayhem—and it is largely caused by alcohol.¹³⁹

Ambulance callouts and emergency department presentations

2.84 Accurate information about ambulance callouts and emergency department presentations associated with methamphetamine use is difficult to ascertain as this data is not consistently collected by ambulance services and emergency departments across the country. There are, however, a number of initiatives to record this information that provide a valuable insight into the growth of methamphetamine-related ambulance callouts and emergency department presentations. Two examples are Turning Point's Ambo Project, which collects Victoria's ambulance callout data, and the data collected by New South Wales (NSW) emergency departments.

Turning Point's Ambo Project

2.85 Turning Point's ongoing initiative titled *Ambo Project: Alcohol and Drug-Related Ambulance Attendances* records ambulance callout trends and the substances involved. It began in 1998 in collaboration with Ambulance Victoria and is funded by the Victorian Department of Health.¹⁴⁰ Data collected identifies crystal methamphetamine-related attendances. Evidence presented in the Ambo Project's 2014–15 report shows a significant growth in the total number of crystal methamphetamine attendances in Victoria between 2013–14 and 2014–15 with an increase of 47.8 per cent (see Table 10 and Figure 3).

138 Dr Louise Roufeil, Australian Psychological Society, *Committee Hansard*, 27 July 2015, p 56.

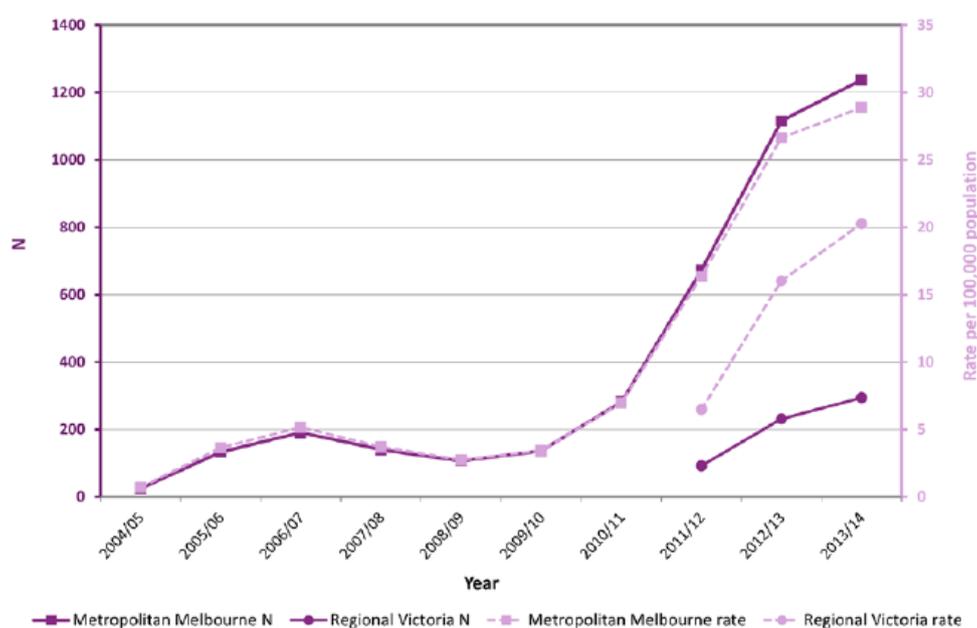
139 Dr Wodak, ADLRF, *Committee Hansard*, 29 July 2015, p. 47.

140 Turning Point, *Ambo-AOD statistics*, 30 November 2016, <http://www.amboaodstats.org.au/> (accessed 5 April 2017).

Table 10: Number of attendances, crystal methamphetamine, in metropolitan Melbourne and regional Victoria, 2013–14 and 2014–15¹⁴¹

	Metropolitan Melbourne	Regional Victoria	All Victoria
2013–14	1240	296	1537
2014–15	1802 (+45.3 per cent increase)	467 (+57.8 per cent increase)	2271 (+47.8 per cent increase)

Figure 3: Crystal methamphetamine-related attendances by year – 2004–05 to 2013–14¹⁴²

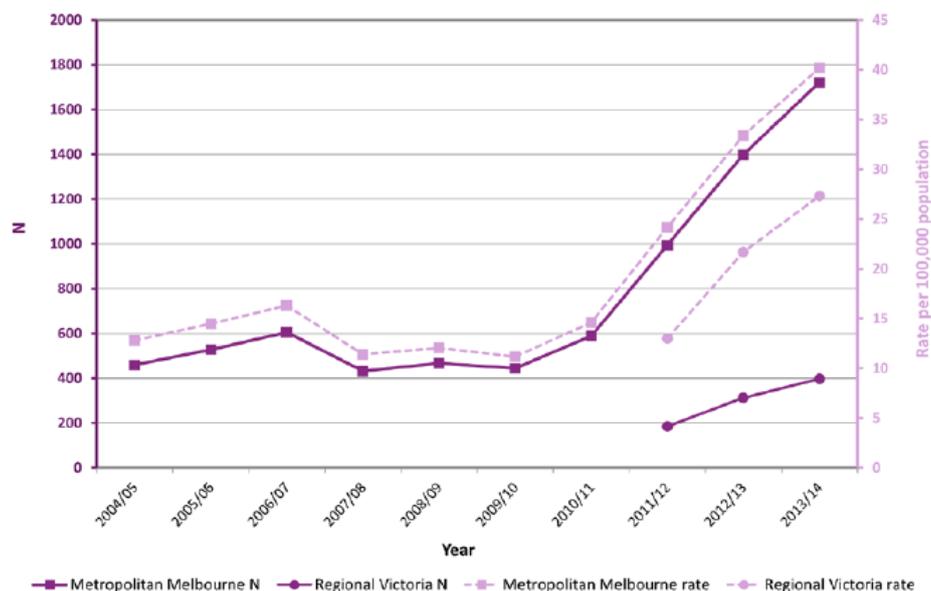


2.86 Since data collection commenced in 2004–05, Victoria's all amphetamine-related ambulance attendances have increased with a notable upward trend since 2010–11 (see Figure 4).

141 Turning Point, *Ambo Project: Alcohol and Drug related Ambulance Attendances 2014–15 Summary Bulletin*, October 2016, p. 3.

142 Turning Point, 'Trends in alcohol and drug-related ambulance attendances in Victoria 2013/14', *Ambo Project: Alcohol and Drug-Related Ambulance Attendees*, August 2015, p. 40.

Figure 4: All amphetamine-related attendances by year – 2004–05 to 2013–14¹⁴³



2.87 The committee is aware that the National Ice Action Strategy (NIAS) supports a commitment to expand the Ambo Project to all states and territories¹⁴⁴ based on the National Ice Taskforce's (NIT) recommendation to establish 'a system to gather and share national ambulance data drawing on the Victorian 'Ambo Project'.¹⁴⁵

New South Wales emergency department presentations

2.88 NSW emergency departments routinely collect data about methamphetamine presentations.¹⁴⁶ This data shows that there has been an increase in these presentations: in 2009–10 there were 470 people attending a NSW emergency department with a methamphetamine-related presentation, in 2015–16 there were 4771 people (see Table 11).

143 Turning Point, 'Trends in alcohol and drug-related ambulance attendances in Victoria 2013/14', *Ambo Project: Alcohol and Drug-Related Ambulance Attendees*, August 2015, p. 40.

144 National Ice Action Strategy, *Our Actions*, 2015, p. 25.

145 National Ice Taskforce, *Final Report*, 2015, p. 153.

146 Definition for presentation includes provisional diagnosis for symptoms: overdose/poisoning, acute alcohol problems, illicit drugs or mental health problems; or where nursing assessment includes reference to terms 'ice' or 'meth'. See, Health Stats NSW, *Methamphetamine related Emergency Department presentations*, 19 July 2016, http://www.healthstats.nsw.gov.au/indicator/beh_illimethed/beh_illimethed (accessed 5 April 2017).

Table 11: Methamphetamine-related NSW Emergency Department presentations, persons aged 16 years and over, 2009–10 to 2015–16¹⁴⁷

Year	Number of persons
2009–10	470
2010–11	699
2011–12	1162
2012–13	1834
2013–14	2455
2014–15	3627
2015–16	4771

2.89 Again, 2010–11 and 2011–12 mark significant upwards shifts in the number of methamphetamine-related presentations to emergency departments.

Deaths linked to methamphetamine use

2.90 During the course of the inquiry, the committee was told that deaths linked to methamphetamine are considered quite rare.¹⁴⁸ However, data from the 2016 household survey demonstrates that the public increasingly believes that meth/amphetamine deaths are quite common. Survey participants ranked meth/amphetamine as the third highest drug thought to cause deaths in Australia (from 8.7 per cent in 2013 to 19.2 per cent in 2016), after tobacco (23.9 per cent in 2016) and alcohol (34.7 per cent in 2016).¹⁴⁹

2.91 Available data has shown an increase in meth/amphetamine deaths. The NDARC reported that accidental drug deaths involving methamphetamine significantly jumped between 2010 and 2011. An examination of drug-related deaths, hospital admissions and treatment services by *The Guardian* suggested that there were

147 Health Stats NSW, *Methamphetamine related Emergency Department presentations*, 19 July 2016, http://www.healthstats.nsw.gov.au/indicator/beh_illimethed/beh_illimethed (accessed 5 April 2017).

148 Mr Sam Biondo, VAADA, *Committee Hansard*, 27 July 2015, p. 31.

149 AIHW, *NDSHS 2016 Key findings table*, <http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129559847> (accessed 3 July 2017).

101 methamphetamine-related deaths in Australia in 2011, 16 more than in 2010.¹⁵⁰ Estimates have also indicated that up to 170 drug-induced deaths involved methamphetamine in 2013.¹⁵¹

2.92 On 28 March 2017, the Victorian Coroner released statistics on the number of people who had died in Victoria from drug overdoses. Since 2009, Victoria has seen the number of drug overdose deaths steadily increase. In 2016, instances where methamphetamine contributed to an overdose death increased by 40 per cent, from 72 to 116 people. Seventy per cent of all fatal overdoses in Victoria have been contributed to poly-drug use.¹⁵²

2.93 A further study was released by the NDRI on 31 July 2017. The NDRI assessed 1649 crystal methamphetamine related deaths between 2009 and 2015 and found 43 per cent of those deaths were caused by an overdose; 22 per cent of deaths were due to natural diseases, such as heart disease. The study found the yearly national death toll had doubled between 2009 to 2015, most of which occurred in rural and regional areas (41 per cent).¹⁵³

2.94 The NDRI's Professor Shane Darke said the results show that crystal methamphetamine 'is a serious public health problem and I think we're right to treat it as such. This is not a beat-up, this is real'.¹⁵⁴ Professor Darke noted that the number of deaths due to crystal methamphetamine appeared to have stabilised, but have stabilised at a worrying level.¹⁵⁵

150 Helen Davidson, 'Methamphetamine deaths in Australia have jumped significantly – report', *The Guardian*, 5 June 2015, <https://www.theguardian.com/australia-news/2015/jun/05/methamphetamine-deaths-in-australia-have-jumped-significantly-report> (accessed 30 March 2017).

151 NDARC, *Methamphetamine deaths increase across Australia and ice use jumps by 52 per cent among people who inject drugs*, 5 June 2015, <https://ndarc.med.unsw.edu.au/news/methamphetamine-deaths-increase-across-australia-and-ice-use-jumps-52-cent-among-people-who> (accessed 5 April 2017).

152 Chloe Booker, 'Drug overdose deaths rise in Victoria', *The Age*, 28 March 2017, <http://www.theage.com.au/victoria/drug-overdose-deaths-rise-in-victoria-20170328-gv8f6k.html> (accessed 5 April 2017).

153 Mr Gavin Coote, 'This is not a beat up: Ice-related deaths doubled over seven years, study finds', *ABC*, 31 July 2017, <http://www.abc.net.au/news/2017-07-31/this-is-not-a-beat-up-study-finds-ice-related-deaths-double/8755172> (accessed 31 July 2017).

154 Mr Coote, 'This is not a beat up: Ice-related deaths doubled over seven years, study finds', *ABC*, 31 July 2017, <http://www.abc.net.au/news/2017-07-31/this-is-not-a-beat-up-study-finds-ice-related-deaths-double/8755172> (accessed 31 July 2017).

155 Mr Coote, 'This is not a beat up: Ice-related deaths doubled over seven years, study finds', *ABC*, 31 July 2017, <http://www.abc.net.au/news/2017-07-31/this-is-not-a-beat-up-study-finds-ice-related-deaths-double/8755172> (accessed 31 July 2017).

2.95 Although the rise in deaths related to methamphetamine is a concern, Professor Roche made a comparison between methamphetamine and the heroin epidemic in the 1990s:

It is probably helpful to remind people that, in 1999 in Australia, 1,000 young Australians died from a heroin overdose. That is pretty catastrophic. I think it is helpful to keep a balance here. We have in Australia dealt with numbers of very severe drug problems. Death is as catastrophic as it is going to get, and we know that the death rate associated with methamphetamine is increasing. So death is the worst possible outcome, and that is the thing that we work extremely hard to prevent. We then work back in terms of a hierarchy of harms after that.¹⁵⁶

Drivers of crystal methamphetamine use

2.96 Despite the negative emotional and health effects of meth/amphetamine use, people continue to use these drugs throughout Australia. Reasons for consuming meth/amphetamine, include to:

- increase productivity (especially in work environments);¹⁵⁷
- increase pleasure and enjoyment (including sexual activities);
- manage emotions;
- increase a sense of belonging;
- replicate perceived 'normative' behaviour;
- expand one's consciousness/heightened awareness; and
- counter the effects of other drugs and/or avoid the negative experience of drug withdrawal.¹⁵⁸

2.97 As described in the ADF's 2015 report *Drugs: the facts*:

People use drugs to relax, to function, for enjoyment, to be part of a group, out of curiosity or to avoid physical and/or psychological pain. Drug use is influenced by a number of factors. Most people use drugs because they want to feel better or different. They use drugs for the benefits (perceived and/or experienced), not for the potential harm. This applies to both legal and illegal drugs.¹⁵⁹

2.98 Another significant driver of methamphetamine use in Australia is inequality. The Ted Noffs Foundation called crystal methamphetamine 'a drug of disadvantage'.¹⁶⁰ Typically, as with other drugs such as heroin, disadvantaged

156 Professor Roche, Flinders University, *Committee Hansard*, 28 July 2015, p. 7.

157 Mr Ryan, Penington Institute, *Committee Hansard*, 27 July 2015, p. 12.

158 ADF, *Submission 51*, p. 6.

159 ADF, *Drugs: the Facts*, <http://adf.org.au/drug-facts/drugs-the-facts/> (accessed 3 July 2017).

160 Mr Mark Ferry, CEO, Ted Noffs Foundation, *Committee Hansard*, 29 July 2015, p. 53.

communities experience the negative impacts of crystal methamphetamine more so than advantaged communities. According to the Ted Noffs Foundation, approximately 80 per cent of their clients are socially and economically disadvantaged.¹⁶¹ Important factors identified by the Ted Noffs Foundation as contributing to this trend include:

- intergenerational drug use and children bearing witness to the dysfunctional use of drugs and alcohol;
- community drug usage that normalises that behaviour for children;
- people who experience homelessness;¹⁶² and
- the difficulties for children to remove themselves from these at risk communities.¹⁶³

2.99 The ADF also identified that those people most at risk of problematic drug use are vulnerable through 'no "fault" of their own' and are significantly influenced by both environmental and biological factors outside of their control.¹⁶⁴ These factors include:

- the emotional distress caused by the lack of employment opportunities, or mental health problems;
- children with learning difficulties and dysfunctional family environments; and
- the lack of positive role models to guide young people to make constructive life choices.¹⁶⁵

2.100 Professor McKetin said there would always be a proportion of the Australian population that will 'indulge in drug taking, and that is related to social acceptability of drug use, availability of drugs, and a variety of other factors'.¹⁶⁶ However, Professor McKetin emphasised that one key predictive factor in determining whether an individual develops a dependency for an illicit drug is that person's resilience.¹⁶⁷

2.101 Professor McKetin listed other factors that may contribute to a user developing a problematic drug habit:

Things like mental health problems, low socioeconomic status, lack of opportunities, all of these things increase the risk of drug problems developing, as does the availability of the drug in the community, and this

161 Mr Ferry, Ted Noffs Foundation, *Committee Hansard*, 29 July 2015, p. 54.

162 Mr Ferry defined homelessness as those who live in refuges, couch surf or live on the street.

163 Mr Ferry, Ted Noffs Foundation, *Committee Hansard*, 29 July 2015, p. 54.

164 ADF, *Submission 51*, p. 11.

165 ADF, *Submission 51*, p. 11.

166 Professor McKetin, ANU, *Committee Hansard*, 9 September 2015, p. 10.

167 Professor McKetin, ANU, *Committee Hansard*, 9 September 2015, p. 10.

is not to be underestimated because now we have high availability of this drug.¹⁶⁸

2.102 Dr Wodak highlighted the importance of discussing the role of inequality in the context of these public health problems, and argued:

A number of public health researchers around the world have come to the conclusion that countries with high levels of inequality—and that includes Australia—have much higher levels of mental health and public health problems such as illicit drug use. It is striking when you compare Australia, a country with high inequality, to Japan and the Scandinavian countries, which have much lower levels of inequality. In all those countries the problems they have with illicit drugs are a fraction of the problems we experience in Australia. Proving this hypothesis is probably beyond us, but the face validity is such that we should be doing it.¹⁶⁹

2.103 The Penington Institute suggested that another contributing factor to Australia's high levels of methamphetamine consumption is the demand for intoxication through drugs (both legal and illegal) and opined that 'we have to deal with the driver for drug consumption, which is, indeed, ourselves. It is the Australian community; it is not a failure of law enforcement. It is a failure of the community'.¹⁷⁰

Price, purity and methods of administration

2.104 The following sections of the report discuss the price, purity and methods of administration of crystal methamphetamine, and how these have changed over time.

Price

2.105 The ACIC's *Illicit Drug Data Report 2015–16* revealed that the price of crystal methamphetamine continues to decline, despite record seizures. Crystal methamphetamine's price per gram across the nation ranged from \$150 to \$1200, down from \$250 and \$1200 per gram in 2014–15.¹⁷¹ The price per gram in 2013–14 was \$300 to \$1600.¹⁷² It was also reported that a point (a tenth of a gram)¹⁷³ of crystal methamphetamine cost around \$20 to \$200, compared to \$50 to \$150 in 2014–15.¹⁷⁴

168 Professor McKetin, ANU, *Committee Hansard*, 9 September 2015, p. 10.

169 Dr Wodak, ADLRF, *Committee Hansard*, 29 July 2015, p. 46.

170 Mr Ryan, Penington Institute, *Committee Hansard*, 27 July 2015, p. 15.

171 ACIC, *Illicit Drug Data Report 2015–16*, p. 46.

172 ACIC, *Illicit Drug Data Report 2014–15*, p. 47.

173 A point is the typical amount of methamphetamine sold on the streets. Approximately a tenth of a gram.

174 ACIC, *Illicit Drug Data Report 2015–16*, p. 46.

2.106 Nationally, in 2015–16 the price per kilogram for crystal methamphetamine ranged from \$75 000 to \$280 000 in 2015–16. The price range in 2014–15 was between \$120 000 and \$280 000.¹⁷⁵

2.107 Professor McKetin discussed the relationship between the price per 'point' and the availability of crystal methamphetamine. She advised that crystal methamphetamine's price (in the Sydney market) has remained relatively stable, suggesting that price has not been a factor driving increased usage:

...the price seems to have been \$50 a point forever, at least in Sydney, and what changes is the purity, the availability. I am sure that there is a relationship. We saw it with heroin, and it was about the dose relationship and the way it was marketed as well. It went from something that you could buy as a gram from a secret dealer that you would have to know personally for a few hundred dollars, and then the price dropped down to about \$200, which was cheap for a gram, but what happened was that people started selling it on the street corner for \$20 or \$30 a cap. That makes it much more accessible...I actually could imagine common sense is like, if you can pay a certain amount of money for a drug that is going to give you a good high for four hours, and you look at the price of alcohol and other drugs, it is going to play a role.¹⁷⁶

Purity

2.108 Although the price of crystal methamphetamine continues to decline, the purity of crystal methamphetamine has increased.

2.109 The *Illicit Drug Data Report 2015–16* outlines the median purity of amphetamine/methamphetamine samples from 2006–07 to 2015–16. Figures 5 and 6 are drawn directly from the report and demonstrate that the purity of methamphetamine samples in particular have increased drastically between 2010–11 and 2015–16.

175 ACIC, *Illicit Drug Data Report 2015–16*, p. 46.

176 Professor McKetin, ANU, *Committee Hansard*, 9 September 2015, p. 12.

Figure 5: Annual median purity of amphetamine samples, 2006–07 to 2015–16 (by state and territory)¹⁷⁷

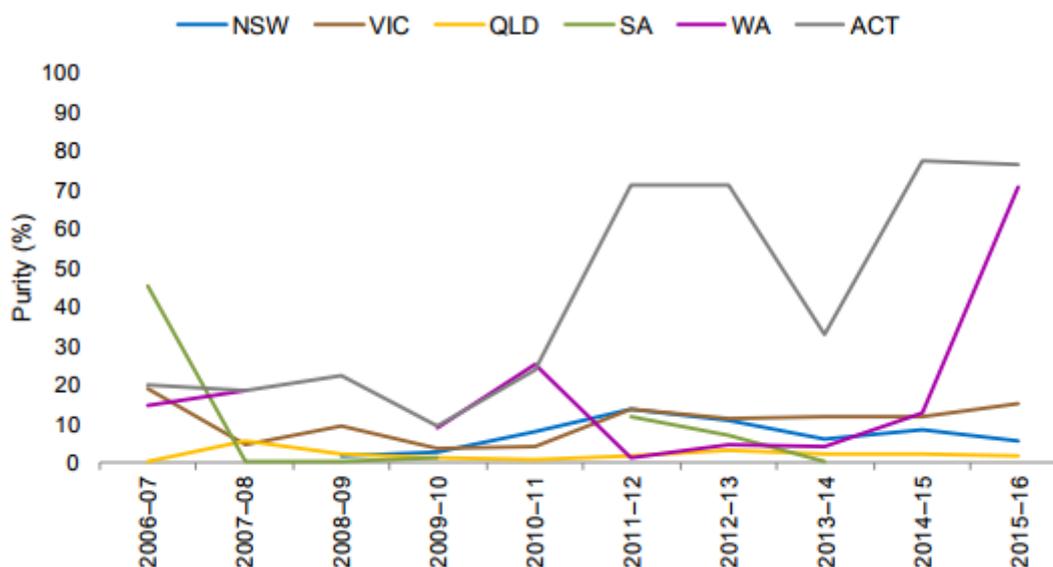
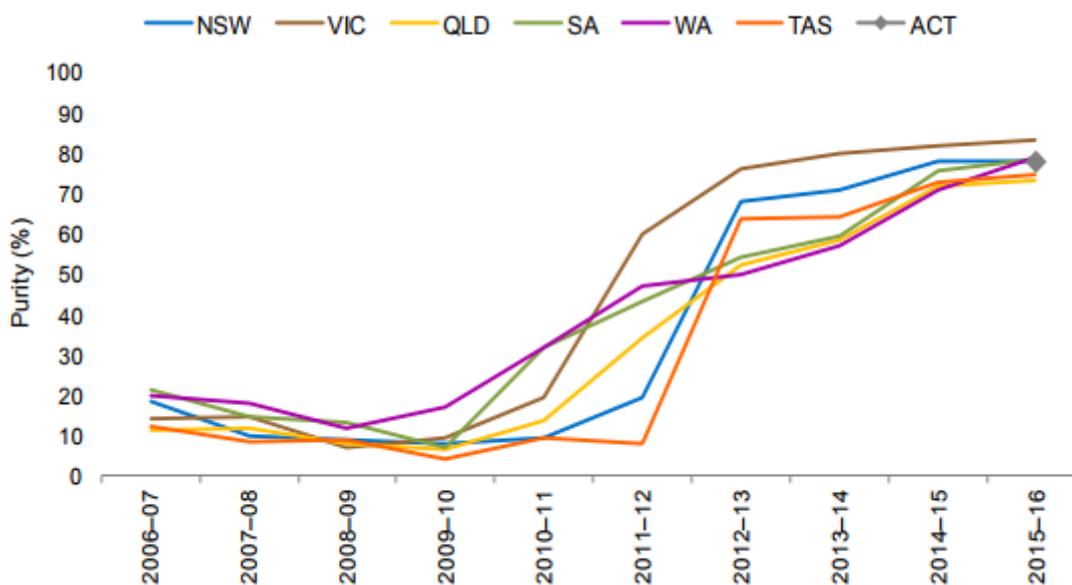


Figure 6: Annual median purity of methamphetamine samples, 2006–07 to 2015–16 (by state)¹⁷⁸



2.110 The quarterly analysis of the median purity of methamphetamine samples in 2015–16 (by state) (see Figure 7) indicates that most states have methamphetamine with purity between 70 to 80 per cent, and that this level of purity remained stable over the course of the year.

¹⁷⁷ ACIC, *Illicit Drug Data Report 2015–16*, p. 47.

¹⁷⁸ ACIC, *Illicit Drug Data Report 2015–16*, p. 48.

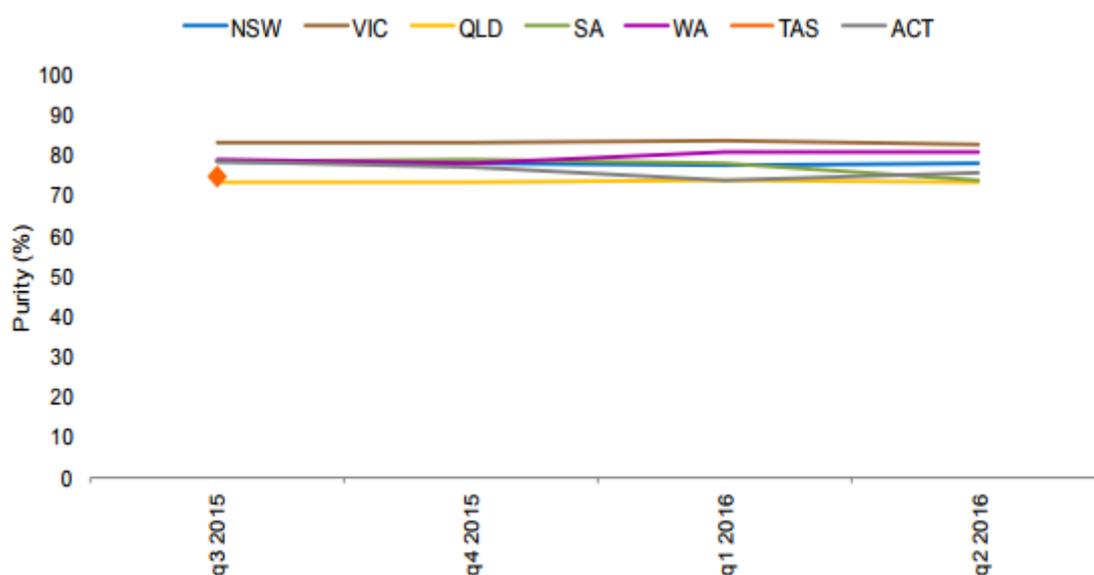
2.111 Participants in the 2015 IDRS remarked that the purity of crystal methamphetamine was 'high' and that high purity methamphetamine was considered 'easy' and 'very easy' to obtain.¹⁷⁹

2.112 A number of submitters discussed the purity of crystal methamphetamine, with many highlighting the increase in purity as a significant concern.

2.113 The NDARC highlighted that crystal methamphetamine is becoming the preferred form of methamphetamine and is increasing in purity, observing:

...the community has moved towards a changed form of the substance. Where traditionally we had seen the powder form more commonly used, we have seen a move towards ice in its crystalline form. That doubled in that population survey in 2013 that we were talking about. That means we are seeing more people taking the crystalline form, which is a purer form, but they are also taking that form more regularly. They are using it more often. We know from a lot of previous work that the crystalline form is generally of much higher purity than the powder form or any of the other forms. If you have an increase in the pure substance being taken more often then you are going to find the potential for harm is, indeed, magnified.¹⁸⁰

Figure 7: Quarterly median purity of methamphetamine samples, 2015–16 (by state)¹⁸¹



2.114 Additionally, the Centre for Population Health at the Burnet Institute spoke of users not necessarily knowing the purity of crystal methamphetamine each time it was

179 NDARC, *Australian Drug Trends 2015. Findings from the Illicit Drug Reporting System*, Australian Drug Trend Series No 145, 2016, p. xvi.

180 Dr Burns, NDARC, *Committee Hansard*, 29 July 2015, p. 23.

181 ACIC, *Illicit Drug Data Report 2014–15*, p. 50.

purchased, a situation that can cause greater harm to the user and the community. Work done by the Burnett Institute shows:

...when someone goes and buys the drug, and they are buying a typical amount, they are typically buying, say, 0.1 of a gram. When they used to purchase it a few years ago, it used to be around 15 per cent pure, and it would cost a certain amount. Then through the end of 2013, the price they paid went up a little bit, but the purity had gone up from, say, 15 per cent to around 70 per cent. So essentially for the same amount of money, you would get a dramatically increased amount of the drug. People who were not used to using such high purity drugs were getting into much more trouble, and that is a really plausible explanation for the increase in ambulance call-outs, the increase in emergency department presentations, and all of those harms that you mentioned in the health domain would easily be accounted for by that change in purity, as well as the change from using powder through to using the crystal form of the drug, which generally is smoked.¹⁸²

Methods of administration

2.115 Crystal methamphetamine is typically administered into the body either by smoking (through a glass pipe) or injecting directly into the bloodstream. According to the School of Social and Political Science at the University of Melbourne, these two forms of use are 'extremely efficient absorption mechanisms...which means you get a bolus dose—a big thump of the drug straight away...[t]hat is going to be a much more intense experience than someone who snorts the drug'.¹⁸³ As noted by Burnet Institute:

If you smoke the drug, the way in which it is metabolised, or the body takes it up, the effect is much quicker than if you were to snort it, as people traditionally did with speed powder.¹⁸⁴

2.116 Professor McKetin agreed that because crystal methamphetamine is primarily smoked, it has become a social drug, unlike injecting methamphetamine, which is a stigmatised behaviour. The ease of passing around a pipe to smoke crystal methamphetamine means users:

...take it to a party and bang, 20 people are exposed to it. It is also because when someone becomes dependent, the main way that they will earn the money to support their drug habit is through dealing. That way they get a ready supply of wholesale price methamphetamine. In doing that, they sell it to their friends...That is how the market operates. If you have someone who is dependent, it is a social drug; they take it to the party and then they start selling it to those friends. There is a potential for this to spread more

182 Professor Dietz, Burnet Institute, *Committee Hansard*, 9 September 2015, p. 2.

183 Associate Professor John Fitzgerald, University of Melbourne, *Committee Hansard*, 27 July 2015, p. 37.

184 Professor Dietz, Burnet Institute, *Committee Hansard*, 9 September 2015, p. 2.

rapidly than what we would have seen with other forms of the drug, because you have the dependence liability and you have the social aspect.¹⁸⁵

Poly-drug use

2.117 Poly-drug use—which involves the use of multiple substances at once—is another issue commonly associated with crystal methamphetamine, especially problematic users, who 'dabble across a range of substances and are polydrug users'.¹⁸⁶

2.118 The committee heard that poly-drug use, including crystal methamphetamine, was a common feature of people seeking treatment for drug addiction. The Salvation Army placed emphasis on this fact, stating that it does not generally see methamphetamine use in isolation:

Once people get into treatment services they are usually polydrug users, so it is very rare to get someone who has only used ice. Very often we will see people having used opiates such as heroin or benzodiazepines such as valium to assist them in the cycle of ups and downs; they would use one of those other drugs to help them come off. Of course, alcohol and ice are quite a difficult combination we see a lot of, particularly because people are able to drink a lot more alcohol without feeling drunk while they use ice. The increased complexity in related health issues is a huge issue for us as well.¹⁸⁷

National data on illicit drug arrests and illicit drug offences recorded in Australia's criminal courts

2.119 The ACIC's *Illicit Drug Data Report* for 2015–16 shows that the number of illicit drug arrests in Australia have continued to rise over the last decade. There were 82 389 arrests in 2006–07; the total increased to 154 538 arrests in 2015–16 (an 87.6 per cent increase).¹⁸⁸ By drug, the ACIC reported the following:

- National ATS arrests have increased by 213 per cent over the last decade, with 15 216 people arrested in 2006–07 and 47 625 people arrested in 2015–16. Proportionally, ATS arrests make up 30.8 per cent of all national illicit drug arrests, a substantive increase from 18.5 per cent in 2006–07.
- The number of cannabis arrests have increased by 40.1 per cent over the last decade, with 56 862 people arrested in 2006–07 and a record 79 643 people arrested in 2015–16. Proportionally, this total has decreased from 69 per cent of all drug arrests in 2006–07 to 51.6 per cent in 2015–16.

185 Professor McKetin, ANU, *Committee Hansard*, 9 September 2015, p. 10.

186 Mr Biondo, VAADA, *Committee Hansard*, 27 July 2015, p. 32.

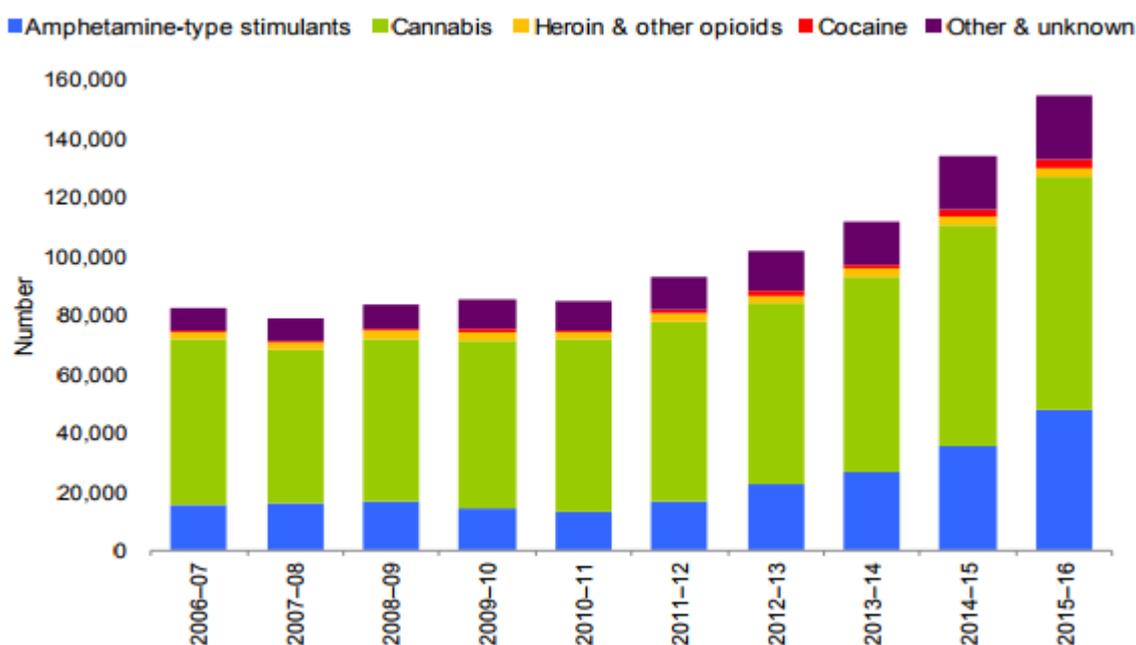
187 Ms Kathryn Wright, Territorial Drug and Alcohol Director, Salvation Army, *Committee Hansard*, 29 July 2015, p. 29.

188 ACIC, *Illicit Drug Data Report 2015–16*, 2016, p. 12.

- Heroin and other opioid arrests have increased by 37.5 per cent, from 2164 in 2006–07 to 2975 in 2015–16. However, as a proportion of all drug arrests this total has decreased from 2.6 per cent in 2006–07 to 1.9 per cent in 2015–16.
- The number of cocaine arrests has increased by 270.8 per cent, from 699 in 2006–07 to 2592 in 2015–16. Proportionally, these arrests represent 0.8 per cent of all drug arrests in 2006–07 and 1.7 per cent in 2015–16.
- Other and unknown drug arrests have substantially increased too, by 191.4 per cent over the past decade. In 2006–07 there were 7448 arrests and in 2015–16 there were 21 703 arrests. As a proportion of all drug arrests this has increased from 9 per cent in 2006–07 to 14 per cent in 2015–16.¹⁸⁹

2.120 Figure 8 shows the number of national illicit drug arrests from 2006–07 to 2015–16 by drug type.

Figure 8: National illicit drug arrests by drug type, 2006–07 to 2015–16¹⁹⁰



2.121 The growth in the number of arrests has correlated with an increase in the number of illicit drug offences (including charges for possession and use) recorded in the criminal courts of each state and territory. The Australian Bureau of Statistics (ABS) provides this data annually. Although this data does not distinguish between drug types, it does provide insight into the broader context of illicit drug use and possession offences in each state and territory.

¹⁸⁹ ACIC, *Illicit Drug Data Report 2015–16*, 2016, p. 12.

¹⁹⁰ ACIC, *Illicit Drug Data Report 2015–16*, 2016, p. 12.

2.122 Key findings from Australian criminal courts for 2015–16 revealed the number of defendants finalised¹⁹¹ for an illicit drug offence has continued to rise. In 2015–16 there were 63 541 defendants finalised with a principal offence for an illicit drug offence(s), an increase from the 59 341 finalised offences in 2014–15. The majority, 59 per cent (37 201) of these 'defendants were charged with offences related to possession or use of illicit drugs'.¹⁹²

2.123 The increase in the number of defendants finalised for possession and use of illicit drugs was highlighted by the ABS on 1 March 2016. The ABS reported the number of defendants finalised for illicit drug offences in 2014–15 had continued to rise, and were at the highest level in the past five years. The 2014–15 figures show an increase of 51 per cent compared to 2010–11. Fifty eight per cent of those finalised for illicit drug offences in 2014–15 were for possession and/or use.¹⁹³ The ABS reported possession/use offences have increased by 21 per cent (5834 defendants in total) compared to 2013–14.¹⁹⁴ Seventeen per cent of illicit drug offences that were finalised were for dealing or trafficking illicit drugs. These increases continue an upward trend in the number of illicit drug cases before Australian courts.¹⁹⁵

2.124 Nationally in 2015–16, there were 56 282 defendants proven guilty for illicit drug offences. Of this total, 35 578 were for possession and/or use offences.¹⁹⁶

191 A finalised defendant is a person or organisation for whom all charges in a case have been formally completed so that they cease to be an item of work. For further information see: Australian Bureau of Statistics (ABS), *Defendants finalised 2015–16*, 2 March 2017, <http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/4513.0~2015-16~Main%20Features~Defendants%20finalised~4> (accessed 8 August 2017).

192 ABS, *Criminal Courts Australia*, 2015–16, 2 March 2017, <http://www.abs.gov.au/ausstats/abs@.nsf/mf/4513.0> (accessed 8 August 2017).

193 ABS, 'Illicit drug offences continue to rise', *Media release*, 1 March 2016, [http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/4513.0~2014-15~Media%20Release~Illicit%20drug%20offences%20continue%20to%20rise%20\(Media%20Release\)~18](http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/4513.0~2014-15~Media%20Release~Illicit%20drug%20offences%20continue%20to%20rise%20(Media%20Release)~18) (accessed 3 February 2017)

194 ABS, *Criminal Courts Australia*, 2014–15, 1 March 2016 <http://www.abs.gov.au/ausstats/abs@.nsf/mf/4513.0> (accessed 3 February 2017)

195 ABS, 'Illicit drug offences continue to rise', *Media release*, 1 March 2016, [http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/4513.0~2014-15~Media%20Release~Illicit%20drug%20offences%20continue%20to%20rise%20\(Media%20Release\)~18](http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/4513.0~2014-15~Media%20Release~Illicit%20drug%20offences%20continue%20to%20rise%20(Media%20Release)~18) (accessed 3 February 2017)

196 ABS, *Defendants proven guilty*, 2015–16, 2 March 2017, <http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/4513.0~2015-16~Main%20Features~Defendants%20proven%20guilty~5> (accessed 8 August 2017).

2.125 Table 12 shows national illicit drug offences for defendants proven guilty by offence type, from 2008–09 to 2015–16.

Table 12: National illicit drug offences for defendants proven guilty by offence type, 2008–09 to 2015–16¹⁹⁷

Year	2008–09	2009–10	2010–11	2011–12	2012–13	2013–14	2014–15	2015–16
Illicit drug offences (total)	34 555	35 713	33 894	35 447	38 914	44 788	52 561	56 282
Import or export illicit drugs	139	191	161	217	191	253	228	186
Deal or traffic in illicit drugs	4792	4736	4463	4684	4753	5678	6262	7106
Manufacture /cultivation of illicit drugs	4806	5066	5037	4877	4578	5085	4964	4519
Possession and/or use of illicit drugs	21 136	21 667	20 380	21 494	24 214	27 145	32 712	35 578
Other illicit drug offences	3678	4053	3848	4178	5169	6620	8394	8888

2.126 The ABS also provides data on the number of defendants finalised for principal illicit drug offences in each Australian jurisdiction. Table 13 shows annual figures of defendants finalised for a principal illicit drug offence in the criminal courts of each state and territory, 2011–12 to 2015–16.

¹⁹⁷ ABS, *Data Cubes*, 2015–16, 31 July 2017, <http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/4513.02015-16?OpenDocument> (accessed 8 August 2017).

Table 13: Annual figures of defendants finalised for a principal illicit drug offence in the criminal courts of each state and territory, 2011–12 to 2015–16.¹⁹⁸

Year	2011–12	2012–13	2013–14	2014–15	2015–16
New South Wales					
Illicit drug offences	10 990	11 935	12 849	14 956	16 445
Victoria					
Illicit drug offences	4147	4461	5010	5543	5499
Queensland					
Illicit drug offences	14 429	16 229	20 120	23 970	25 158
South Australia					
Illicit drug offences	3282	3573	3688	3310	3223
Western Australia					
Illicit drug offences	5787	6420	7740	9841	11 394
Tasmania					
Illicit drug offences	1 127	895	720	797	820
Northern Territory					
Illicit drug offences	654	768	580	773	831
Australian Capital Territory					
Illicit drug offences	180	137	150	148	164

198 ABS, *Data Cubes*, 2015–16, 31 July 2017, <http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/4513.02015-16?OpenDocument> (accessed 8 August 2017).

Committee comment

2.127 It has traditionally been difficult to get an accurate picture of the extent of crystal methamphetamine use in Australia due to weaknesses with data collection methods, largely surveys, and the likelihood of respondents under-reporting drug use. For example, the AIHW household survey is susceptible to under-reporting arising from negative popular views and media reporting that may influence drug users' willingness to accurately self-report illicit drug use. However, new approaches to data collection and analysis, such as the *National Wastewater Drug Monitoring Program*, mark a significant step forward in gaining a more thorough understanding of drug use in this country. The committee anticipates that future wastewater analysis by the ACIC will build a more accurate picture of drug use in Australia and assist governments, service providers and academics to develop more targeted policies and strategies to address illicit drug use.

2.128 Crystal methamphetamine use is not necessarily a one way path to more problematic consumption for all users. However, the drug can have serious short- and long-term physical and psychological impacts and these should not be underestimated.

2.129 As demonstrated in this chapter, specialists have identified groups within our community that are more at risk of developing problematic crystal methamphetamine use and face greater hurdles when attempting to access treatment. For this reason, culturally appropriate AOD resources must be directed towards and treatment available to vulnerable communities, that is Australia's young people, regional and remote communities, Indigenous communities and the LGBTI community.

2.130 The committee also heard that problematic crystal methamphetamine use has been linked to social and economic disadvantage and inequality. The committee agrees that this is a feature of crystal methamphetamine use in Australia and one that brings a complex dimension to the problem. However, it can be glib to say that socioeconomic disadvantage and inequality cause problematic drug use and the committee is concerned that this can have the effect of further stigmatising or marginalising crystal methamphetamine users on account of their socioeconomic circumstances. Genuine and serious consideration must be given to the inter-relationship between people's socioeconomic circumstances, their drug use and their ability to access AOD services and treatment. In the committee's opinion, drug users' socioeconomic status must be used to inform appropriate and effective policy responses and must not simply be used to identify a particular group of drug users.

2.131 The committee is concerned that despite large, and in some cases record seizures occurring at Australia's borders, the price, purity and availability of crystal methamphetamine remains cheap, high, and readily accessible. In no way does the committee wish to diminish from the efforts and successes of our law enforcement and border protection agencies; however, the evidence before it suggests to the committee that law enforcement strategies alone will not solve the crystal methamphetamine problem in Australia.

2.132 Indeed, Mr Ken Lay APM, Chair of the NIT, announced at the release of the NIT's final report that 'ice use is not a problem we can solve overnight, and not something we can simply arrest our way out of'.¹⁹⁹ The committee shares this view. The NIT and the NIAS appear to mark a significant shift in and a renewed focus on Australia's national drug strategy, and an attempt to rebalance the three pillars (supply, demand and harm reduction). Submitters and witnesses to the inquiry, from both the health and law enforcement sectors, consistently told the committee that crystal methamphetamine use should be approached primarily as a health issue and not a law enforcement issue.

2.133 The subsequent chapters of this report and the committee's second report will consider current and future responses to crystal methamphetamine use in Australia. In particular, the remainder of this report will focus on law enforcement strategies and their effectiveness.

199 Nation Ice Taskforce, *Final Report*, 2015, p. ii.

